DOCUMENT RESUME

ED 438 407 CE 079 691

TITLE	A New Beginning: The Child Health Manual.
INSTITUTION	Peace Corps, Washington, DC. Information Collection and Exchange Div.
REPORT NO	PC-ICE-T0102
PUB DATE	1999-10-00
NOTE	338p.
AVAILABLE FROM	Peace Corps, Center for Field Assistance and Applied Research, Information Collection and Exchange, 1111 20th Street, NW, 5th Floor, Washington, DC 20526.
PUB TYPE	Guides - Non-Classroom (055)
EDRS PRICE	MF01/PC14 Plus Postage.
DESCRIPTORS	Adult Education; Behavioral Objectives; *Child Health; *Course Content; *Developing Nations; Diseases; Foreign Countries; Guidelines; Health Education; *Health Programs; Health Services; Infant Care; Lesson Plans; Nutrition; Pediatrics; Physical Health; Primary Health Care; Program Implementation; Public Health; Sick Child Care; Teaching Methods; Training
IDENTIFIERS	*Peace Corps

ABSTRACT

This manual was designed to be used as part of the pre-service training technical curriculum for Peace Corps health programs. The topics in the manual were selected from a needs assessment of Peace Corps personnel around the world. The manual consists of five parts and an introduction, the Trainer's Guide, which contains an overview of the manual and gives a brief synopsis of each section's content, notes on delivering the sessions, and guidelines on how to design a technical curriculum and an integrated training curriculum. Part One: Child Health--Country Overview provides country-specific information on health problems and activities in the host country. Part Two: Fundamentals of Child Health contains maternal and child health information, diseases, and immunizations. Part Three: Entering the Community contains exercises that help trainees understand the importance of working with the community while they perform health work. Part Four: Understanding the Setting leads trainees through the work of gathering general information about the community and its health issues. The last section, Part Five: Addressing Child Health Issues looks at how to design, implement, monitor, and evaluate health activities or interventions, and also trains participants in giving health presentations. Each section contains 3-12 lesson plans for sessions, each of which consists of objectives, overview, time needed, staff needed (if applicable), materials needed, preparation, delivery steps, and resources. (KC)

Reproductions supplied by EDRS are the best that can be made
from the original document.

CE

ED 438 407

A NEW BEGINNING

THE CHILD HEALTH MANUAL

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

CE079691

BEST COPY AVAILABLE

PEACE CORPS

INFORMATION COLLECTION AND EXCHANGE

This publication was produced by the Peace Corps Center for Field Assistance and Applied Research. It is distributed through the Information Collection and Exchange (ICE). For further information or additional copies, please contact ICE and refer to the ICE catalog number that appears on the publication:

PEACE CORPS
CENTER FOR FIELD ASSISTANCE AND APPLIED RESEARCH
INFORMATION COLLECTION AND EXCHANGE
1111 20TH STREET NW - FIFTH FLOOR
WASHINGTON, D.C. 20526

Add your experience to the ICE Resource Center. Send your materials to ICE or the Center for Field Assistance and Applied Research so that we can share them with other development workers. Your technical insights serve as the basis for the generation of Peace Corps manuals, reprints, and training materials. They also ensure that the Peace Corps is providing the most up-to-date, innovative problem-solving techniques and information available to you and your fellow development workers.

A NEW BEGINNING:

THE CHILD HEALTH MANUAL

PEACE CORPS

OCTOBER 1999

INFORMATION COLLECTION AND EXCHANGE
PUBLICATION NO. T0102

CONTENTS

Acknowledgments vii

Trainer's Guide

Introduction 1

How to Use this Manual 2

Content of the Manual Parts: An Overview 3

Notes on Delivering these Sessions 5

Using this Manual in Community-Based Training 6

Using this Manual with Trainees in Other Programs 8

Designing the Technical Training Curriculum 10

Developing an Integrated Training Curriculum 12

Resources and Reference Materials 18

Appendix A:
Sample Schedule for Community-Based Training 25

Appendix B:
Sample Schedule for Pre-Service Training 31

Part One: Child Health—Country Overview

Introduction and Summary of Sessions 33

1. Overview of Child Health Issues 35
2. Common Causes of Child Mortality 38
3. American and Host-Country Health Beliefs 41

Part Two: Fundamentals of Child Health

Introduction 47

Summary of Sessions 48

1. The Child and the Mother 50
2. The Healthy Child 56

3. Childhood Diseases and their Symptoms ... 62
4. Assessing the Sick Child ... 65
5. Checking the Child's Immunization Status ... 78
6. Determining Weight for Age ... 83
7. Counseling the Mother about Breast-feeding and Complementary Foods ... 87
8. Water and Sanitation Diseases and Their Prevention ... 90

Part Three: Entering the Community

Introduction and Summary of Sessions ... 97
1. Why is it Important to Work with the Community? ... 99
2. Getting Involved in Your Community ... 103
3. Establishing Credibility in Your Community ... 108
4. Working with Counterparts and the Community ... 114
5. Cross-Cultural Critical Incidents ... 122

Part Four: Understanding the Setting

Introduction ... 127
Summary of Sessions ... 128
1. Framework for Community Analysis ... 130
2. Community Mapping
    (1) Designing a Community Mapping Tool ... 134
    (2) Mapping the Community ... 137
    (3) Processing the Community Mapping Exercise ... 139
3. Description vs. Interpretation ... 142
4. Observation Skills
    (1) Developing Observation Tools ... 145
    (2) Observation Exercise ... 154
    (3) Processing the Community/Home/Clinic Observation Exercise ... 157
5. Styles of Communication ... 160
6. Interviewing
    (1) Writing Interview Questions ... 162
    (2) Developing an Interview Tool ... 166

  - (3) Interview Exercise 169
  - (4) Processing the Interview Exercise 171

7. Time Line of Daily Activities

  - (1) Time Line of Daily Activities: Mothers and Health Workers 173
  - (2) Processing the Time Line Exercise 177

8. Child Health Assessment: A Practicum

  - (1) Conducting a Child Health Assessment 179
  - (2) Case Presentations 182

9. Gathering Data from Child Health records

  - (1) Looking at Child Health Records 184
  - (2) Processing Information Gathered from Child Health Records 190

Part Five: Addressing Child Health Issues

Introduction 193

Summary of Sessions 194

1. Starting with the Right Perspective

  - (1) What is an Accomplishment? 196
  - (2) Whose Activity Is It? 200

2. Problems or Causes 203

3. Analyzing the Data

  - (1) Analyzing the Data (gathered in 'Understanding the Setting') 206
  - (2) Analyzing the Data with the Community 212
  - (3) Processing the Session with the Community 215

4. Causes of a Health Problem: Immediate and Ultimate 218

5. Behavior Change

  - (1) The Process of Behavior Change 224
  - (2) Factors Affecting Behavior Change 227

(3) Evaluating Target Behaviors 231

6. Identifying Solutions 238

7. Selecting an Intervention 244

8. Designing an Intervention 1: Community Assets 249

9. Designing an Intervention 2: The Process 252

10. Designing an Intervention 3: A Practicum

(1) Designing an Intervention with the Community 260

(2) Processing the Session with the Community 264

11. Monitoring and Evaluating an Intervention

(1) Establishing Baseline Data 266

(2) Monitoring an Intervention 271

(3) Making Adjustments in an Ongoing Intervention 277

(4) Evaluating an Intervention 280

12. Health Presentations and Principles of Adult Learning

(1) Quiz for Presenters 285

(2) Training Adults 290

(3) The Great Myth of Training 297

(4) Presentational Voice 301

(5) Designing and Delivering a Health Talk 304

8

ACKNOWLEDGMENTS

This manual began with an extensive needs assessment with field staff, including Country Directors, Associate Peace Corps Directors (APCDs), Project Directors, and Technical Trainers. It was field tested in Ecuador and Sri Lanka. The Peace Corps expresses its gratitude for all who assisted, including the Volunteers who gave feedback and advice.

The Peace Corps acknowledges the World Health Organization Child and Adolescent Health and Development program for allowing reprints of sessions, charts, and entire booklets for resource materials.

The Peace Corps also acknowledges the contributions of the following people and organizations for their assistance: the Maternal and Child Health Participating Agency Service Agreement with the Office of Health and Nutrition at USAID for funding; BASICS for access to state-of-the-art materials on child health, Charlotte Storti for research and draft in collaboration with Shelley Smith and Angela Churchill, Health Program Specialists for the Peace Corps; Felicity Williams and Judee Blohm for revisions; Pam Dimeo, Anne Latimer and Susan Tuller for editorial assistance; and Pat Bartlett for graphic design.

This manual is dedicated to the Trainees and Volunteers in health programs around the world and to the mothers and children with whom they work.

TRAINER'S GUIDE

INTRODUCTION

The central purpose of this manual—and of any pre-service training (PST) based on it—is to replicate in training, as nearly as possible, the experiences of a Peace Corps Volunteer conducting health work in a village or community. The manual takes the Trainees through the same sequence of events that Volunteers go through so that Trainees may develop the same skills and knowledge that they need to carry out the most common health assignments.

HOW WAS THIS MANUAL DESIGNED?

These materials are designed to be used as part of the pre-service training technical curriculum for Peace Corps health programs. The topics in the manual were selected from an extensive needs assessment conducted with country directors, associate Peace Corps directors (APCDs) for health programs, health trainers, Volunteers, and Trainees around the world. While significant differences exist in health programs from country to country, certain topics emerged as essential to most health work, and it is these topics that are covered in the manual. The manual's content is designed to meet the needs of a wide variety of health Trainees.

WHO IS THIS MANUAL FOR?

The manual's primary audience is health technical trainers. Some technical trainers will use all or most of these exercises and others will use only selected parts. In both cases, trainers will probably want to supplement sessions from the manual with additional sessions of their own.

Two other potential audiences are:

- Technical trainers for other sectors (i.e., agriculture or education) that might include health work in their sector projects; and
- Trainers for all types of community development programs (see Part Two of this guide).

HOW TO USE THIS MANUAL

Different trainers will use this manual in different ways, depending on a variety of factors, including:

- the technical background of the Trainees;
- the particular jobs Trainees are being prepared for;
- the trainer's own background and experience.

The manual can be adapted to the specific needs of the post.

Depending on these variables, you, the technical trainer, may choose to adopt the entire manual for the technical training component of PST; or you may use only parts of the manual and combine it with materials from other sources; or you may use the whole manual and additional materials. Experienced trainers may prefer to use some of their own training materials to cover certain topics in the manual and to cover topics not addressed.

You may be able to use some exercises as they are, with little or no adaptation. For others, you may want to cover the topics addressed, but you may have to make changes to the exercises. The goal is to address as many of the key topics as possible. The specific needs of every PST cannot be met in a generic manual. Some exercises may not be relevant to some PSTs.

HOW IS THIS MANUAL ORGANIZED?

The manual consists of five parts: a trainer's guide, an in-country overview of child health, fundamental health issues, entering the community, understanding the setting, and addressing health issues in and with the community.

Overall, the manual achieves a balance between the technical health component and the process of community development. Specific health issues and the fundamentals of health are covered in Parts One and Two. Parts Three, Four, and Five discuss community involvement;

information gathering; project design, implementation, and evaluation; cross-cultural exercises, etc.

The materials are organized so that earlier sessions prepare participants for subsequent ones. Each part of the manual builds on previous parts.

CONTENT OF THE MANUAL PARTS: AN OVERVIEW

TRAINER'S GUIDE

The Trainer's Guide contains an overview of the manual, including its purpose, how it is designed, and for whom it is designed. It gives a brief synopsis of each section's content, notes on delivering the sessions and guidance on how to use this manual in a community-based training (CBT), as well as in center-based training. (Two sample training schedules and designs are in the appendix.)

The Trainer's Guide also includes guidelines on how to design a technical curriculum and how to develop an integrated training curriculum with the entire training staff. The section begins with guidelines on how to design a country-specific technical training curriculum in collaboration with the associate Peace Corps director (APCD) for the health sector, and the training director. The trainer's section then discusses ways to integrate the technical component of training with the other components. This section contains information about the references used in the sessions, as well as some other recommended resources.

Overall, the manual achieves a balance between the technical health component and the process of community development.

PART ONE:
CHILD HEALTH–COUNTRY OVERVIEW

This brief section provides important country-specific information on health problems and activities in the host country. This information should be supplemented by guest speakers.

PART TWO:
FUNDAMENTALS OF CHILD HEALTH

This section contains important child health information that will probably be new to most generalists. This part of the manual could be presented elsewhere in the PST, but many generalists are anxious about their lack of child health knowledge and are eager to get some basic health training as soon as possible. If you have a group of specialists, with a child health background, you may be able to skip some sessions in this part.

PART THREE:
ENTERING THE COMMUNITY

These exercises help Trainees understand the importance of working with the community while they perform health work. The exercises also show Trainees how to become integrated into and accepted by the community. This section is introduced midway in the manual so that Trainees will always have community involvement in mind as they carry out the information gathering and intervention planning exercises in Parts Four and Five. Volunteers should conduct the activities in Parts Four and Five with community members; Trainees should be thinking about how to involve the community even as they practice these sessions as Trainees.

PART FOUR:
UNDERSTANDING THE SETTING

Now that Trainees have been given basic health and community entry information, they can begin the important work of gathering general information about the community and its health issues, in particular. Before Trainees actually begin *implementing* a health intervention program (the focus of the next section), they first need to understand the setting or context in which they will be working.

Trainees should be thinking about how to involve the community even as they practice these sessions in training.

PART FIVE:
ADDRESSING CHILD HEALTH ISSUES

After the Trainees understand health conditions and problems in the community, they are ready to think about ways to address these issues. Hence, this part of the manual looks at how to design, implement, monitor, and evaluate health activities or interventions, and also trains participants in a key skill: giving health presentations.

The manual takes a Trainee through the entire process of designing and executing a health intervention from start to finish--from community entry, to data collection, to needs assessment, and finally, to intervention design, execution, and evaluation. Not every Trainee will have to do this as a Volunteer, of course, but every Volunteer will be part of one or more health project in the community and should, therefore, be familiar with the various tasks that make up such an effort. Most health Volunteers play two major roles in their communities: they become involved in pre-existing health interventions (e.g., working at a clinic) and they help devise new ones. In both roles, they need the skills and knowledge provided by the five sections of this manual.

NOTES ON DELIVERING THESE SESSIONS

The most important suggestion—also the most obvious—is that you read each session or exercise, which contains trainer notes and Trainee handouts, well in advance of actually delivering it. Advance reading will help you to determine what information is relevant. It will also help you decide if you need to make changes or if you can deliver the exercise as it is written.

Many sessions will probably need to be amended somewhat to suit the specific needs of a particular PST. This alteration should be done before you find yourself in front of a group about to introduce an exercise. Changes might need to be made for any of the following reasons:

- prior background and skill level of the training group
- the kind of work Volunteers will be doing
- amount of training time
- other sessions that have covered similar topics
- circumstances in the community or the country
- nature and availability of training staff and other resources

Advance reading will help you to determine what information is relevant.

Some sessions will take only about 15 to 20 minutes. Some of the shorter sessions may be used as introductory exercises (or "icebreakers") for the longer sessions or to introduce a country-specific technical session (as described in the session **Common Causes of Child Mortality**, p. 38).

The remaining notes are keyed to the major headings of the exercises:

OBJECTIVES	Two or three brief statements describing what you are trying to accomplish in the session.
OVERVIEW	This describes the key content of the session and its importance. You should include some or all of the information in the overview and objectives, when you introduce the session in Step 1 of your delivery.
TIME	The times given are approximations. In some circumstances, the session will go more quickly; in others, it will take longer. Trainers should read through the steps and assign a probable amount of time for each one, given their circumstances.
STAFF	This heading is only found if resource people, such as Ministry of Health (MOH) or other host-country officials, current Volunteers, Peace Corps staff, or other training staff, are needed to carry out the session.

MATERIALS Materials necessary for the sessions are listed here. Handouts listed in this section are found at the end of the session.

PREPARATION This heading is only used if you need to do special preparation prior to the session.

DELIVERY **STEP 1** is a crucial moment. It is the time in all of these exercises when you explain in a lucid and convincing manner what this activity consists of and why you are asking Trainees to do it. You need to show quite clearly how the particular knowledge or skill the session teaches is something Trainees need to do their job. You should also relate the exercise to earlier and later sessions in the training—how it fits into and complements the rest of training. In short, you should put the session into the wider context of the entire technical component. Before you stand before the group, be sure to give some thought to what you are going to say during delivery.

REMAINING STEPS: Read through the various steps carefully so you understand the flow of the activity. You should also try to anticipate any problems or questions which might come up at each stage. You may want to eliminate or add some steps. In either case, it is better to realize this ahead of time and not when you're standing in front of the group.

CLOSING: At the end of each session reiterate important ideas.

RESOURCES This heading is used if there are particular publications or other materials which might be helpful to you in preparing the session.

The basic approach and focus of this manual is on how to enter a community, gather information, and work with the community in addressing health issues.

USING THIS MANUAL IN COMMUNITY-BASED TRAINING

The sessions in this manual lend themselves readily to the community-based approach to training (CBT). The primary philosophy of CBT is to expose Trainees early to the realities of living and working in their assigned country. Similarly, the basic approach and focus of this manual is on how to enter a community, gather information, and work with the community in addressing health issues. Many sessions, especially in Parts Three, Four, and Five, are activities that should be done in and with the community.

In the manual you will find some sessions that are more theoretical and are therefore more appropriate for seminar-style sessions that are usually held on weekends during a CBT.

CBT provides a variety of venues for carrying out technical training: weekend classroom seminars for the more theoretical sessions; small group sessions at the Trainee sites; practical, hands-on sessions in the community; and opportunities for field trips in small groups. Below are suggestions for where the various parts and sessions of the manual can be carried out. Please see Appendix A for a sample CBT schedule using the sessions from this manual.

SESSIONS	SUGGESTED POSITION IN CBT
Part One: In-Country Overview	During a weekend seminar
Part Two: Fundamentals of Child Health	During several weekend seminars or in small groups at the Trainee sites
Part Three: Entering the Community	At the Trainee sites in small groups (may be interspersed with sessions in Part Four)
Part Four: Understanding the Setting	At the Trainee sites and in the community
Part Five: Addressing Child Health Issues	The more theoretical sessions can be done during weekend seminars. These include the behavior change module, monitoring and evaluation, and the theoretical side of health presentations and adult learning. The remaining sessions can be done in small groups at the Trainee sites and in or with the community.

The ideal pre-service training balances theory and knowledge with practice and application of skills. CBT sets the stage for this ideal, but it also requires a great deal of effort and careful planning by the technical staff. Ideally, one or several technical facilitators (depending on the number of Trainees and Trainee sites) should be available to assist with the sessions at the Trainee sites and organize the community activities. These tasks usually fall on the language staff, who may lack technical knowledge or skills and need to be trained as technical facilitators. A CBT also requires careful, advance planning to get the community involved. In addition, logistical support is a necessity, especially vehicles and drivers to transport technical staff and equipment to and from the Trainee sites.

The sessions in this manual can easily be done in a traditional center-based training, as well, where classroom learning is the norm. In such trainings, the hands-on, experiential sessions should be done in the community, ideally during a series of weekly or biweekly visits that feature the practical application of concepts covered earlier in the classroom. Needless to say, these visits require considerable planning and coordination. Periodic visits to the community are preferable to a short field experience where all practical aspects of the technical training are done at once. Appendix B is a sample PST schedule that includes sessions from this manual.

USING THE MANUAL WITH TRAINEES IN OTHER PROGRAMS

This manual can be adapted for any Peace Corps program that has community development as part of its core technical content. Parts Three, Four, and Five are designed to train Volunteers in the *process* of community entry, information gathering using basic Participatory Rural Appraisal (PRA) tools, and working with the community to analyze problems and causes, define solutions, and come up with feasible interventions. This basic process is the same for all community development work, and all the sessions in these three parts of the manual are applicable for any PST. In some cases, the technical trainer can use the sessions more or less as they are, merely changing the words "health" to "agricultural extension" or "water and sanitation," or "youth development."

Collaboration with the APCD is key to a successful training program.

DESIGNING THE TECHNICAL TRAINING CURRICULUM

Collaboration with the APCD is key to a successful training program. Begin by learning as much as possible about the in-country program:

- Meet with the APCD to discuss the Peace Corps program and to understand what the APCD needs and wants out of the training. This discussion should focus on the program *purpose, goals, objectives, milestones*, and *tasks* (better known as the *PGOMT*). Ask for a copy of the project plan and PGOMT.
- Read the project plan and look at the task analysis of the Volunteer job. If the APCD has not done a task analysis, then you need to do one before designing the technical curriculum.
- Look at the tasks from the task analysis and develop technical training competencies, which become the training session objectives. A task may involve Trainees having or developing several competencies. Here are some examples:

TASKS	COMPETENCIES = OBJECTIVES
1. Give health talks on proper nutrition and prevention of malnutrition and related illnesses in children under five to mothers of young children.	1a. To understand the fundamentals of child health and essential child health messages. (From the session **Overview of Child Health Issues**, p. 35) 1b. To understand the concepts of the healthy child and prevention of childhood illnesses. (**The Healthy Child**, p. 56 and Water Supply and Sanitation, p. 90) 1c. To understand and apply the concepts of an integrated approach to assessing child health. (**Assessing the Sick Child: Case Studies**, p. 65) 1d. To identify local practices concerning nutrition and the feeding of children and be able to counsel the mother about child nutrition, especially breastfeeding and complementary foods. (**Counseling the Mother About Breast-feeding and Complementary Foods**, p. 87) 1e. To understand important points in training adults. (**Training Adults**, p. 290) 1f. To understand why health talks often fail to achieve their purpose and why some people who have heard a health talk do not change their behavior. (**The Great Myth of Training**, p. 297) 1g. To practice delivering a health talk. (**Delivering a Health Talk**, p. 304)
2. Gather information, using PRA tools, about the community in general and health in particular.	2a. To use a framework for organizing and categorizing health data. (**Framework for Community Analysis**, p. 130) 2b. To design and use various PRA tools such as mapping, observation, interviewing, and constructing a time line of daily activities. (**Designing a Community Mapping Tool**, p. 134; **Mapping the Community**, p. 137; **Processing the Community Mapping Exercise**, p. 139; **Developing Observation Tools, Observation Exercise**, p. 145; **Processing the Community/Home/Clinic Observation**, p. 157; **Writing Interview Questions**, p. 162; **Developing an Interview Tool**, p. 166; **Interview Exercise**, p. 169; **Processing the Interview Exercise**, p. 171; **Time Line of Daily Activities: Mothers and Health Workers**, p. 173; **Processing the Time Line Exercise**, p. 177) 2c. To define the differences between description and interpretation when making observations. (**Description vs. Interpretation**, p. 142)

(continued on page 10)

TASKS	COMPETENCIES = OBJECTIVES
	2.d. To understand key communication concepts, identify important cultural differences concerning these concepts, and consider the implications of these differences for gathering data through interviews and verbal interactions. (**Styles of Communication**, p. 160)
3. Plan and carry out appropriate interventions or projects with the community.	3a. To understand the importance—and necessity—of establishing credibility in the community. (**Establishing Credibility in Your Community**, p. 108) 3b. To identify key health problems in and with the community. **Analyzing the Data** (gathered in 'Understanding the Setting'), p. 206; **Analyzing the Data with the Community**, p. 212; **Processing the Session with the Community**, p. 215) 3c. To understand the stages and criteria for changing behavior. (**The Process of Behavior Change**, p. 224; **Factors Affecting Behavior Change**, p. 227; **Evaluating Target Behaviors**, p. 231) 3d. To identify solutions and select an appropriate intervention. (**Identifying Solutions**, p. 238; **Selecting an Intervention**, p. 244) 3e. To list community assets and practice the steps of designing a health intervention. (**Designing an Intervention 1: Using Community Assets**, p. 249; **Designing an Intervention 2: The Process**, p. 252) 3f. To design and implement an intervention with the community. (**Designing an Intervention with the Community**, p. 260; **Processing the Session with the Community**, p. 264)

- Meet with the program and training officer (PTO) or training officer (TO), if appropriate. (Some countries do not have these staff positions.) Discuss the training goals and objectives and obtain information about previous training designs that include Trainees' recommendations.
- If there is time, visit Volunteer sites and interview as many Volunteers as possible about their jobs and their PST to determine what they see as important to technical training. (If the technical trainer is a former Volunteer, then this may not be necessary.)

The next step is to design the technical training curriculum:

- Become familiar with the contents of this manual. Begin by reading the Trainer's Guide and the introduction to each section.

- Make an outline of the topics/sessions to be delivered on the basis of the project plan, tasks, and competencies required.
- Select appropriate sessions from this manual that meet the needs of the program.
- Select and integrate country-specific sessions as needed. These may be available from previous PSTs or the technical trainer may need to design these sessions.
- Design the technical curriculum. Pay close attention to the flow and sequencing of sessions so that one session builds on the next. Review the order of sessions in this manual for guidance. Trainees need to understand how each exercise relates to the assignments they will have as Volunteers. Tying the sessions together helps Trainees make sense of their training and keeps their interest and attention.
- Prepare a tentative week-by-week schedule and begin writing session plans to include objectives, overview, time/ materials/ staff needed, preparation, and delivery. (This has been done for you in this manual.)
- Meet with the training project director to discuss ideas and plans for the overall training design. Then go over the technical training curriculum and week-by-week schedule in detail. (This should also be done with the APCD if possible.)

  Discuss the logistical support needs of the technical program: availability of vehicles, training space or locations, technical support staff, training materials (notebooks, 3-ring binders for handouts, and reading materials, etc.), audiovisual equipment, the use and availability of outside guest speakers, and field trips and how to manage them.

  Find out what other core topics, sessions, and activities are planned or scheduled and be prepared to negotiate the number of hours, the time of day, and the days of the week that are required to meet the technical goals and objectives of the program.

  Other sessions may overlap with or duplicate the technical sessions, for example, sessions on community development, or Women in Development (WID)/Gender and Development (GAD). Discuss these with the project director and offer a solution to this potential problem. Make sure that the flow and content of the technical training is not compromised.

- Based on the above discussion, make any changes or adaptations necessary to the technical curriculum design and schedule. Make changes to the sessions selected from the manual if necessary.

> ***...make any changes or adaptations necessary to the technical curriculum design and schedule.***

DEVELOPING AN INTEGRATED TRAINING CURRICULUM

As stated in the introduction to this trainer's guide, the central purpose of this manual is to replicate in training the experiences Volunteers may encounter as they carry out their health work in the village or community. The overall goal of training is to prepare Trainees to live and work in the country and community to which they are assigned. This means giving Trainees technical, language, and cross-cultural skills and teaching them how to take care of their own personal health and safety—all in 10 to 12 weeks. To be efficient and effective, the training staff must design a curriculum that integrates all of the necessary components of training. This task is easier said than done. To give this process of developing an integrated curriculum a head start, the components of this manual have been integrated as much as possible.

In designing an integrated training curriculum, collaboration and coordination with the other training staff is important. The norm in most PSTs has been to present the language, cross-cultural, technical, and personal health and safety components as separate entities. Staff cross-cultural issues and management, logistical, and budget issues frequently interfere with integration. But the reality is that Volunteers live and work in a setting where language, technical, cross-culture, health and safety, and community are integrated and intertwined and this is what PST must prepare them for.

Ideally, a separate workshop would work solely on integration, but lack of time may prohibit this.

The training sessions in this manual integrate language, cross-culture, health and safety, and community development. A matrix on page 15 indicates which sessions integrate into which components. In all but a few of those sessions marked with an 'X', trainer notes offer guidance as to which resource staff or persons are needed for the session and how to use this staff in the session.

Most PSTs have a staff development or training of trainers (TOT) workshop several weeks prior to the Trainees' arrival. The TOT workshop is an ideal time for you to present an overview of the technical curriculum and discuss with the other staff an integrated approach to the PST. Overviews can also be done for the other components, and then the staff can develop an integrated approach together. Unfortunately, many other matters need to be covered during the few short days allotted to staff development or TOT. Ideally, a separate workshop would work solely on integration, but lack of time may prohibit this. If time does not permit the staff to develop an integrated curriculum, you can refer to the following recommendations:

Language: Only nine language sessions are marked with an X on the Integrated Curriculum Development matrix. This is because the language coordinator and/or staff are asked to participate in these sessions as training partners. Ideally, however, each technical session should have a complimentary language session. To facilitate this, give the language coordinator and staff an overview of the technical program, including a week-by-week description of the sessions. Give the language trainers copies of all the Trainee handouts you plan to use. With the language trainers develop a list of vocabulary words that match those in each Trainee handout and ask them to teach this vocabulary in language class during the same week the technical session is being given.

Cross-Cultural: Several sessions address working in the health field in a cross-cultural context. In other sessions, a cross-cultural component is included. In some of these, Trainees are asked to complete some of the exercises in ***Culture Matters*** prior to the technical session. You should review with the cross-cultural coordinator the sessions that require his/her participation and that use exercises from ***Culture Matters***. In this way, you and the cross-cultural coordinator can coordinate your schedules and avoid repetition of sessions and conflicts in timing. The cross-cultural coordinator needs to understand what cross-cultural skills are required by the Trainees throughout the technical training, and during which sessions, and adjust his/her schedule of sessions accordingly. If it is not possible for the cross-cultural coordinator to adjust his/her schedule, then you should know what cross-cultural sessions are being taught, and when, so that you can refer to them.

Personal Health and Safety: Only one session in this manual uses the Peace Corps medical officer (PCMO) as a resource, but several other sessions deal directly with personal health issues, especially in Part Two. These sessions are indicated with an 'X' on the matrix. The PCMO, an excellent resource for any health program, can assist the technical trainer in many ways. The trainer should meet with the PCMO to go over the technical training curriculum. Because the PCMO may be dealing with some of the same health problems in the health and safety sessions, it would be wise to know what the PCMO is covering. This way the technical trainer can build on these sessions and integrate some of the main points, albeit with a focus on the health program.

Community Development: Prior to developing this manual, an extensive needs assessment of the field was conducted and a review of all the health volunteer activity descriptions and project status reviews was carried out. It was determined that the primary focus of this manual should be on community development, that is community entry, community mobilization, participatory rural appraisal (PRA), working with the community on problem solving and coming up with solutions and interventions as defined by the community. Therefore, two-thirds of this manual is devoted to community development using health as the context.

The project director, APCD, and other training staff may be planning sessions on community development. If this is the case, we suggest you go over the materials and sessions you plan to use in the training with other training staff and integrate their sessions with yours wherever possible to avoid repetition. If, for example, the cross-cultural coordinator wants to do a session on mapping or shadowing a mother from the ***Participatory Analysis for Community Action*** (PACA) manual as a cross-cultural session, and you want to do similar sessions from this manual, then you should discuss the goals and objectives of each and work together to obtain the outcomes that you both want.

Women play a significant and integral role in the health of their children.

PGOMT: As stated in the beginning of this section, the key to the success of any technical training is to work closely with the APCD to ensure the project goals, objectives, milestones, and tasks (PGOMT) are being met by the training design. Therefore, several sessions respond to and incorporate the individual post project plans. The APCD is asked to lead and/or participate in these sessions and present information on and represent the perspective of the Peace Corps program. You should meet with the APCD to go over the finalized integrated curriculum, get his/her input, and make any changes or adjustments necessary.

WID/GAD: By definition, anything that addresses child health or community health involves the women in the community. Women play a significant and integral role in the health of their children. Several sessions in this manual are particularly important in integrating women in development (WID) and gender and development (GAD) themes. Sessions on community mapping, timeline of daily activities, observation, interviewing, and facilitation complement similar sessions found in the ***Gender and Development Training Manual***: the PACA tools in Booklet 5 and the skills training in Booklet 4. Other sessions in which the principles and concepts of WID and GAD play a significant role are noted on the matrix. In this manner, the manual supports Peace Corps' initiative on WID and GAD.

If the project director plans on including sessions on WID/GAD in the PST, it would be helpful for you to coordinate your plans with those of the WID/GAD trainer. Together you should discuss any overlapping sessions and come to an agreement on how to integrate the sessions or mutually support each other's sessions so that the technical points are not lost. Also, you should use similar language and mutually reinforce each other's messages.

INTEGRATED CURRICULUM DEVELOPMENT

A matrix showing how the other components of training are integrated into the Child Health Training Manual

Section	Session	Language[1]	Cross Cultural	Health and Safety	Community Development	PGOMT	WID/ GAD
Part One: Child Health Country Overview	Introduction		X		X	X	X
	1. Overview of Child Health Issues In Country			X	X	X	X
	2. Common Causes of Child Mortality in Developing Countries			X			
	3. American and Host Country Health Beliefs		X				
Part Two: Fundamentals of Child Health	Introduction					X	
	1. The Child and the Mother			X			X
	2. The Healthy Child			X			X
	3. Childhood Diseases and their Symptoms			X			X
	4. Assessing the Sick Child: Case Studies			X			X
	5. Checking the Child's Immunization Status			X			X
	6. Determining Weight for Age						X
	7. Breast-feeding and Complementary Foods		X	X			X
	8. Water Supply and Sanitation		X	X			X

---

[1] See page 12, paragraph 5, for an explanation on the integration of language and technical components.

Section	Session	Language[1]	Cross Cultural	Health and Safety	Community Development	PGOMT	WID/ GAD
Part Three: Entering the Community	Introduction		X		X		
	1. Why is it Important to Work with the Community		X		X		
	2. Getting Involved in Your Community		X		X		
	3. Establishing Credibility in Your Community		X		X		
	4. Working with Counterparts and the Community		X		X		
	5. Cross-Cultural Critical Incidents	X					
Part Four: Understanding the Setting	Introduction		X		X		
	1. Framework for Community Analysis				X		
	2. Community Mapping	X			X		X
	3. Description vs. Interpretation		X				
	4. Observation Skills	X			X		X
	5. Styles of Communication		X		X		
	6. Interviewing	X	X		X		
	7. Time Line of Daily Activities	X	X		X		X
	8. Child Health Assessment: Practicum	X	X	X	X		X
	9. Gathering Data From Child Health Records	X		X	X		

---

[1] See page 12, paragraph 5, for an explanation on the integration of language and technical components.

Section	Session	Language[1]	Cross Cultural	Health and Safety	Community Development	PGOMT	WID/ GAD
Part Five:	Introduction				X	X	
Addressing Child Health Issues	1. Starting with the Right Perspective				X		
	2. Problems or Causes						
	3. Analyzing the Data	X	X		X	X	X
	4. Causes of a Health Problem: Immediate and Ultimate						
	5. Behavior Change				X		X
	6. Identifying Solutions				X		X
	7. Selecting an Intervention				X		X
	8. Designing an Intervention 1: Using Community Assets				X		X
	9. Designing an Intervention 2: The Process				X		
	10. Designing an Intervention 3: Practicum	X	X		X	X	X
	11. Monitoring and Evaluating an Intervention				X	X	X
	12. Health Presentations and the Principles of Adult Learning						

---

[1] See page 12, paragraph 5, for an explanation on the integration of language and technical components.

RESOURCES AND REFERENCE MATERIALS

The following publications are essential complements to the material in this manual. Those preceded by a number are available through the Peace Corps Information and Exchange (ICE) office in Washington.

R0111 **Assess and Classify the Sick Child Age Two Months Up to Five Years.** Integrated Management of Childhood Illnesses, Module 14.B. Prepared by WHO's Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) and UNICEF 1995. 150 pp.

A practical, hands-on training manual for health workers that provides an integrated approach to the assessment and management of the sick child. Describes how to ask the mother about a child's problem, check for general danger signs; look for the four main symptoms: cough or breathing-difficulty, diarrhea, fever, and ear problems; assess the child further for signs related to the main symptom; classify the illness according to the signs which are present or absent; check for signs of malnutrition and anemia and classify the child's nutritional status; check the child's immunization status; and assess any other problems. Includes exercises, case studies, quizzes, and visual aids. It also includes a chart that gives step-by-step guidelines on how to assess and classify sick children so that signs of disease are not overlooked.

R0110 **Counsel the Mother.** Integrated Management of Childhood Illnesses, Module 14.E. Prepared by WHO's Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) and UNICEF 1995. 63 pp.

A practical, hands-on training manual for health workers who are counseling mothers about feeding children from birth to 2 years of age. Includes age-specific feeding recommendations and guidelines on how to assess a child's feeding; identify feeding problems; counsel the mother about feeding problems; increase fluids during illness; and give relevant advice on when to return for follow-up visits and immunizations. It also offers a section on counseling the mother about her own health. Includes exercises, role plays, case studies, and quizzes.

T0087 **Culture Matters: The Peace Corps Cross-Cultural Workbook.** (Peace Corps ICE) 1997. 256 pp.

Practical, interactive workbook for Volunteers in all programs. Guides the reader through the cross-cultural experience, the major concepts in the intercultural field, and presents exercises, stories, quotations, and descriptive text designed to aid the Volunteer in successfully adapting to the new culture. Examines the behaviors and values of people in other countries and offers ways to compare their behavior to that of Americans. An excellent resource for trainers, Trainees, and Volunteers. Illustrated.

HE349 **Emphasis Behaviors in Maternal and Child Health: Focusing on Caretakers' Behaviors to Develop Maternal and Health Programs in Communities.** John Murray, Gabriella Newes Adeyi, Judith Graeff, Rebecca Fields, Mark Rasmuson, Rene Salgado, Tina Sanghvi. Technical Report published for USAID by the BASICS Project 1997. 38 pp.

Describes the work of a multidisciplinary team of medical and behavioral specialists who developed a list of sixteen emphasis behaviors that if practiced by caretakers, could improve maternal and child health in communities. The report provides criteria for identifying emphasis behaviors including their impact on multiple disease areas, demonstrated relationship with mortality and morbidity, impact on the most important public health problems in developing countries, measurability, and their feasibility and cost effectiveness. The emphasis behaviors fall under five categories: reproductive health practices; infant and child feeding practices; immunization practices; home health practices; and care-seeking practices. Provides a selection process and strategies for implementing an appropriate program for the local context, as well as how to monitor and evaluate results. Contains a worksheet for prioritizing emphasis behaviors, a behavior analysis scale, and resource guides on information gathering.

HE231 **Facts for Life: A Communication Challenge.** Peter Adamson with Glen Williams. (UNICEF) 1990. 78 pp.

Intended for those who communicate essential child health messages to families. Well written with an easy to read format. Chapters include: What Every Family and Community has a Right to Know About, Timing Births, Safe Motherhood, Breast-feeding, Child Growth, Immunization, Diarrhea, Coughs and Colds, Home Hygiene, Malaria, and AIDS. Can be used by educators to support justification of health programs to policy makers. Can assist village health workers with "catchy" themes for program marketing. Provides a starting point for further discussion of relevant issues.

HE347 **Integrated Management of Childhood Illnesses (IMCI) Chart.** Integrated Management of Childhood Illnesses. Prepared by WHO's Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) and UNICEF 1995. 36 pp.

A quick reference chart for assessing and classifying the sick child and counseling the mother about feeding her sick child. An essential companion to modules 14.B and 14.E of the Integrated Management of Childhood Illnesses.

The following resources are highly recommended:

HE275 **Communication for Health and Behavior Change, A Developing Country Perspective.** Judith A. Graeff, John P. Elder, and Elizabeth Mills Booth. (Jossey-Bass) 1993, 205 pp.

Based on the experience of the Academy for Educational Development's HealthCom Project (financed by USAID) which worked with local governments to improve health communication in developing countries. Describes the behavior analysis theory, which focuses on the behavior change process as it applies to communication for improving children's health. Individual chapters discuss the steps of health communication methodology—assess, plan, train, monitor, and maintain—along with the behavioral concepts and tools that apply to each.

Community Assessment and Planning for Maternal and Child Health Programs: A Participatory Approach in Ethiopia. Karabi Bhattacharya, John Murray, Wondimu Amdie, Mengistu Asnake, Mulugeta Betre, Paul Freund, Tekleab Kedamo, Workenesh Kereta, and Paul Winch. Technical Report published for USAID by the BASICS Project 1998. 35 pp.

This report summarizes the use of a participatory approach to community assessment and planning in five communities in Ethiopia. The activity used participatory and quantitative methods to enable health staff and the communities to jointly identify and prioritize health problems and develop a plan to solve them. The planning process was conducted in four phases: identifying partners and building partnerships; selecting emphasis behaviors; exploring reasons for the behaviors; and developing intervention strategies. Concrete community action plans resulted, calling for improved quality and availability of health services, training of health workers, community organization and participation, and health education. Provides valuable, clear, concise, and practical guidelines for community assessment and planning, including lessons learned, which can be applied in many Peace Corps health programs. Also gives a short description of a training workshop and field-testing of this approach in Zambia.

Community Risk Assessment Tool Box: A Manual for Peace Corps Volunteers Working with Micronutrients. Susan C. Yang with Angela Churchill (Peace Corps ICE). In preparation, 1999.

This manual contains practical tools to help the Volunteer assess the knowledge, attitudes, practices, and behaviors of the community regarding nutrition and health in a way that encourages as much participation as possible. It is divided into different tools for the kitchen, market, garden and farm, school, mothers, clinic, and community each containing activities that are relevant to the tools. These activities include direct observation, focus group discussions, mapping, timelines, seasonality/disease calendars, survey questionnaires, growth monitoring, and getting information from clinic records. Contains guidelines on how to conduct each activity including very specific and comprehensive questions to ask. Also contains a comprehensive list of indicators which can selectively be used to monitor a project or intervention. Although the focus is on micronutrients, the activities can be adapted easily to other sectors.

Control of Communicable Diseases Manual. Abram S. Benenson, Editor (American Public Health Association) 1995, 577 pp.

The primary aim of this book is to provide accurate information on common as well as exotic and rare diseases for public health workers in government and voluntary health agencies, including those working in foreign countries. It is a handy reference for field workers and has a standard format for each disease entity including identification, occurrence, mode of transmission, incubation, periodic, and preventive measures. It covers topics from HIV/AIDS to amoebic dysentery, to measles, tetanus, smallpox, and warts. Although it provides very technical information, it is a useful resource to have on hand for those Trainees and Volunteers who want to have more detailed, scientific information on diseases. (The PCMO in-country may have a copy on hand for review).

M0054 **Gender and Development Training Manual.** (Peace Corps ICE) 1998. 400 pp.

This comprehensive manual is the product of the Gender and Development Training Initiative which seeks to institutionalize the consideration of gender issues throughout Peace Corps. It contains eight booklets which provide the background and development of the project; training designs for various participants; session plans and handouts; and insights from the field. They are organized so that only the booklets needed can be taken out for any particular purpose. Each booklet is short enough to make copying of pages manageable. The booklets are numbered so that they can be returned for future use.

WS113 **Just Stir Gently: The Way to Mix Hygiene Education with Water Supply and Sanitation.** Marieke T. Booth (IRC International Water and Sanitation Centre) 1991. 171 pp.

Promotes hygiene education by relaying information on conditions and practices that help to prevent water and sanitation diseases. Directed towards integrating hygiene education with aspects of water supply and sanitation projects. Offers strategies on decision making in hygiene education; negotiation and cooperation among government agencies, donor agencies, and health institutions; and better planning and management of hygiene education programs. Provides examples of integrating traditional beliefs with the "germ theory of disease" and strong guidance on project monitoring and evaluation. Presents sample lesson plans.

M0042 **Nonformal Education Manual**. (Peace Corps ICE) 1989. 163 pp.

Demonstrates how the techniques of nonformal education (NFE) can be used by virtually all Peace Corps Volunteers. Emphasizes full-scale community participation at all stages of development. Uses examples of Volunteer experiences to illustrate the nature and principles of NFE. Includes information on adult learning, identifying people's needs, planning and evaluating NFE activities, working with groups, and developing appropriate materials for NFE activities.

T0054 **The Peace Corps Programming and Training System Manual.** (Peace Corps ICE) 1994. 336 pp. In revision, 1999.

The Peace Corps manual for standards of programming and training, which provides the agency with a monitoring and evaluation system integrated into the programming process. Includes procedures for assessing, modifying, monitoring, and evaluating existing programs. Also contains material on key aspects of the recruiting process, as well as data on applicant availability.

T0083 **Peace Corps Training.** (Peace Corps ICE) 1994. 79 pp.

A supplement to the Peace Corps Programming and Training System Manual. Focusing on training. Explains Peace Corps training standards and the process of linking training with programming; describes many aspects of staff training; provides detailed information on Trainee assessment process; and offers guidelines for training evaluation.

T0082 **Programming and Training for Peace Corps Health Projects.** (Peace Corps ICE) 1994. 80 pp.

A supplement to the Peace Corps Programming and Training Systems Manual that focuses on health projects. Provides an overview of Peace Corps projects, and discusses new programming directions, sector assessment, project development, training, and evaluation as they relate specifically to the health sector. Includes examples to illustrate the process.

T0104 **Promoting Powerful People: A Process for Change.** (Peace Corps ICE) In revision, 1999.

Using nutrition as the context, this training manual teaches Volunteers the process of helping people help themselves. Through various exercises in and with the community, the Volunteer (or Trainee) learns how effective this simple process is when applied to an activity or a project. Not only does the manual train Volunteers in the process, but it teaches them the skills to carry out the process, including: how to listen and observe in the community so they can understand the community's needs and problems; how to discuss and decide with community members what solutions/actions should be taken to solve those problems; how to communicate effectively with community members (counseling, training, facilitating group discussions); and how to develop and use print, folk media, and locally recorded materials. Each session includes notes to trainers in sectors other than nutrition, so they can adapt the materials to their own training needs. Also includes needed vocabulary for each session which can be linked to language training and an excellent section on basic maternal nutrition.

T0088 **Sourcebook for Community-Based Training Programs.** (Peace Corps ICE) 1997. 75pp.

Provides a basic overview of the community-based training design, followed by a step-by-step guide to planning and developing such a design for a Peace Corps pre-service training program. In addition, the manual discusses in detail some of the key elements that define and set apart the decentralized training model from other programs. Issues of training program support are also discussed.

T0103 **Culture Matters Trainer's Guide.** (Peace Corps ICE) 1998. 120 pp.

An excellent resource for the cross-cultural trainer that contains trainer notes for selected exercises from **Culture**

Matters: The Peace Corps Cross-Cultural Workbook. These are considered core exercises for pre-service training and are particularly appropriate for large groups. Also contains a section on using **Culture Matters Workbook** in pre-service training and a list of additional resources for cross-cultural trainers.

APPENDIX A:
SAMPLE SCHEDULE FOR THE TECHNICAL COMPONENT OF A COMMUNITY-BASED TRAINING

COMMUNITY HEALTH CBT TRAINING
SRI LANKA

Week	Time Needed*	Sesson Theme/Activity**	Exercises from Manual	Community Responsibility
1 Nov. 10-15, 1997		**Healthcare Systems in Sri Lanka and the Role of Healthcare in Community Development**		Prior to training, meet with and establish working groups in the communities with Sarvodaya and Samurdhi members. Explain their role and responsibilities in working with the trainees.
	1.5 hours	**Seminar:** Introduction to the Healthcare Systems in Sri Lanka (Director, Family Health Bureau and APCD)	Part 1, sessions 1 and 2	
			Part 2, session 1: The Child and the Mother—as a self-administered quiz ***Reading: Facts for Life : A Communication Challenge.***	
2 Nov. 17-22		**Community Entry and Gathering Information/ PRA**		**Community Meeting:** Introductions. Explain purpose and goals of working with the community. Review activities to be carried out over the next few weeks.
	2 hours	**Seminar:** Introduction to the philosophy and uses of PRA (APCD)		
	1.5 hours	Introduce framework for community analysis, community mapping, and observation skills.	Part 4, sessions 1, 2, 3, 4	
	1 hour	**In the Village:** Introduction to the community groups Begin making observations and mapping the community	Part 3, sessions 1, 2, 3, 4	
	2 hours	Do sessions on entering the community and working with counterparts and the community		

* Estimated. With one or two exceptions, does not include timing of community activities.

** All sessions, unless otherwise noted, will be conducted by the technical trainer. The language trainers, cross-cultural coordinator, and APCD will assist the tech trainer in carrying out the community activities where needed.

Week	Time Needed*	Sesson Theme/Activity**	Exercises from Manual	Community Responsibility
3 Nov. 24-29		**Strategies for Analyzing Assets, Problems and their Causes and Looking for Solutions**		Carry out mapping and observation exercises in and with the community.
		Seminar:		
	2 hours	Gender in Development – Part 1 (Prema Gamage and PCV]		**Community Meeting:** Discuss findings from community mapping and observation exercises.
	1 hour	Leadership Styles in Sri Lanka		
		In the Village:		Identify key health problems with the community
	2 hours	Complete mapping and observation exercises Process/discuss findings	Part 4, sessions 2.3 and 4.3	
	1-2 hours	Discuss difference between causes and problems and analyze the data gathered through PRA activities	Part 5, sessions 1-4	
			Readings: ***Culture Matters*** – Chapter 3: "Communication Styles"	
4 Dec. 1-6		**Overview of Health Issues, Beliefs, and Practices**		Shadow a mother and do a timeline of daily activities.
		Seminar:		
	2 hours	Gender in Development Part II [Prema and PCV]		**Community Meeting:** Discuss and identify possible solutions to key health needs/problems from the community's point of view.
	2 hours	Overview of Health Problems in Sri Lanka and in the Community [Dr. Harendra De Silva]		
	1 hour	Health beliefs and practices	Part 1, session 3	
		In the Village:		
	2 hours	Behavior Change Module Discuss and Identify Possible Solutions	Part 5, session 5 Part 5, session 6	
	1 hour	Compare Community and PCT Views – Discuss Similarities and Differences (after community meeting)		
	1 day	Shadow a mother or woman in the village and do a timeline of her daily activities	Part 4, session 7 ***Readings:*** ***Emphasis Behaviors in Maternal and Child Health: Focusing on Caretakers Behaviors to Develop Maternal and Child Health Programs (USAID)*** ***Culture Matters:*** Culture in the Workplace, Chapter 4	

36

Week	Time Needed*	Sesson Theme/Activity**	Exercises from Manual	Community Responsibility
5 Dec 8-13 Dec. 10-13: Site Visits	2 hours 1.5 hours	**Child Health Issues in Sri Lanka** **Seminar:** Malnutrition and Other Childhood Diseases (Dr. Mrs. Dulani De Silva) Introduce the integrated approach to managing the sick child and do case studies **In the Village:** Visit a clinic and gather information on types of diseases/prevalence of malnutrition	Part 2, session 4 Part 4, session 9 ***Readings:*** ***Assess and Classify the Sick Child Age 2 months up to 5 Years (WHO)***	Community Leaders accompany PCTs to the clinic
6 Dec. 15-20	1 hour 1.5 hours 2 hours	**Maternal Health Issues in Sri Lanka** **Seminar:** Maternal Health [Nurse Midwife] Foods: Beliefs and Practices Counsel the mother about breast-feeding and complementary foods Traditional Health Systems: Ayurvedic and Homeopathic [Guest Speaker] **In the Village:** Visit a nurse Midwife in Action Collect Information on breast-feeding and feeding practices in the Community	Part 2, session 7 ***Readings:*** ***Counsel the Mother*** [about Breast-feeding and Complementary foods]	Community Leaders accompany PCTs in the field activities **Community Meeting** with mothers and women to discuss breast-feeding and weaning beliefs and practices.

Week	Time Needed*	Sesson Theme/Activity**	Exercises from Manual	Community Responsibility
7 Dec. 22-27 Dec. 24-26 Christmas Tour	1 hour	**Water and Sanitation Programs** **Seminar:** Overview of Water and Sanitation Issues [Public Health Inspector] **In the Village:** Visit a well and latrine construction site Do Water Supply and Sanitation Exercise Observe/gather information on how wells and toilets are constructed. Find out how projects got started, what resources were needed and where the resources come from.	Part 2, session 8	Christmas celebration for Community
8 Dec. 29–Jan. 3	4 hours	**Working with the Community in Selecting Interventions** **Seminar:** Facilitation Skills Workshop [Myrna Sethunga] **In the Village:** Do session on Selecting an Intervention Work with the Community Group to select an intervention	Part 5, session 7 ***Readings:*** ***Community Assessment and Planning for Maternal and Child Health Programs: A Participatory Approach. (USAID)***	**Community Meeting:** The community groups work with the PCTs to select an intervention

Week	Time Needed*	Sesson Theme/Activity**	Exercises from Manual	Community Responsibility
9 Jan. 5-10		**Planning and Implementing an Intervention**		**Community Meeting:** The community groups work with the PCTs to identify assets and plan the intervention following the steps/ guidelines in session V. 10. [This intervention or "project" should be something that can be carried out in the village with the community before the end of training.]
		Seminar:		
	2 hours	Introduction to SPA [APCD] Proposal Writing ; Writing Letters to NGOs, Community Leaders, etc. [APCD, Tech Trainer and PCV]		
	1-2 hours	Panel Discussion with Community Health/ Development Volunteers [Barbara, Franklin, Allison, Sharon, Yvette] Do session on Cross-Cultural Critical Incidents	Part 3, session 5	
	2 hours	Trainees present their intervention plan, the resources they will need/use, and the timeline for accomplishing the intervention		
		In the Village: Identify assets and plan the intervention Do a timeline of steps/activities that need to be done to implement the intervention	Part 5, sessions 8-10	
10 Jan. 12-17		**Setting Up a Monitoring System**		**Community Meeting:** The community groups and PCTs make final preparations for 'Project Day'
		Seminar:		
	1.5 hours	Monitoring and Evaluating an Intervention	Part 5, session 11	
	.5 hour	Education System and Learning Styles in Sri Lanka		
	2-4 hours	Non-Formal Education Techniques in Sri Lankan Context (APCD); Making Visual Aids		
	4-6 hours	Mini-Workshop in "Teaching English" [TESL PCV]	***Readings:*** ***Nonformal Education Training Module (ICE)***	
		In the Village: Make final preparations for 'Project Day'		

Week	Time Needed*	Sesson Theme/Activity**	Exercises from Manual	Community Responsibility
11 Jan. 19-24		**Presenting Results of the Intervention/Feedback**		Carry out intervention or "project" with the community
		Seminar:		
	2 hours	Report out to each other on what worked and what didn't work in the interventions		
	1-2 hours	Reflections on the experience/process Documenting the experience The Experiential Learning Cycle		
		In the Village: Carry out interventions with the community		

APPENDIX B: SAMPLE SCHEDULE FOR THE TECHNICAL COMPONENT OF PRE-SERVICE TRAINING

Week	Sessions	Estimated Time	Exercises from the Manual
1	**Introduction to the Program: Project Plan and Volunteer Roles/Responsibilities**	2 hours	
	Overview of the Technical Training Component	1 hour	
	Health care Systems In-Country	1.5–2 hours	Part 1, sessions 1 & 2
2	**Fundamentals of Child Health:**		
	• The Child and the Mother	45–60 min.	Part 2, session 1
	• The Healthy Child	20–30 min.	Part 2, session 2
	• Childhood Diseases and their Symptoms	20 min.	Part 2, session 3
	• Assessing the Sick Child	60–90 min.	Part 2, session 4
	• Checking a Child's Immunization Status	30 min.	Part 2, session 5
	• Determining Weight for Age	15 min.	Part 2, session 6
	• Counsel the Mother: Breast-feeding and Complementary Foods	60–90 min.	Part 2, session 7
	• Water and Sanitation Diseases and their Prevention	30–45 min.	Part 2, session 8
	Health Beliefs and Practices:		
	• American and Host Country Health Beliefs	30–45 min.	Part 1, session 3
	• Country Specific Beliefs and Practices		
	Field trip to a clinic, district hospital, and/or traditional health provider	1 hour	
3	**Entering the Community:**		
	• Why is it Important to Work With the Community?	30 min.	Part 3, session 1
	• Getting Involved in the Community	30 min.	Part 3, session 2
	• Establishing Credibility in the Community	30–45 min.	Part 3, session 3
	• Working With Counterparts and the Community	1 hour	Part 3, session 4
	Introduction to Participatory Rural Appraisal (PRA) Tools	1 hour	
	Framework for Community Analysis	20–30 min.	Part 4, session 1
	Community Mapping Exercise	1/2 day	Part 4, sessions 2.1-2.3
	Cross-Cultural Critical Incidents	30–45 min.	Part 3, session 5
	Panel Discussion With Volunteers	2 hours	
4	**Understanding the Setting**		
	• Description vs. Interpretation	15–20 min.	Part 4, session 3
	• Observation Exercise	4–6 hours	Part 4, sessions 4.1–4.3
	• Timeline of Daily Activities	1 day	

Week	Sessions	Estimated Time	Exercises from the Manual
5	**Understanding the Setting (cont.)**		
	• Styles of Communication	15–20 min.	Part 4, session 5
	• Interviewing Skills and Practice	4 hours	Part 4, sessions 6.1–6.4
	Addressing the Health Issues		
	• What is an Accomplishment? Whose Activity is It?	30–40 min.	Part 5, sessions 1.1–1.2
	• Distinguishing Between Genuine Health Problems and Their Causes	10–15 min.	Part 5, session 2
	• Analyzing the Data Gathered Through PRA Activities	30 min.	Part 5, session 3.1
	Meet With Community Leaders, Members, and/or Counterparts		
	• Prepare Trainees and Select Facilitator	30–60 min.	
	• Analyzing the Data With the Community	1–2 hours	Part 5, session 3.2
	• Processing the Community Meeting	30 min.	Part 5, session 3.3
6	**Addressing the Health Issues (cont.)**		
	• Causes of a Health Problem	30–40 min.	Part 5, session 4
	• The Process of Behavior Change	90 min.	Part 5, sessions 5.1–5.3
	• Identifying Solutions	45–60 min.	Part 5, session 6
	• Selecting an Intervention	30 min.	Part 5, session 7
	• Designing an Intervention	60–90 min.	Part 5, sessions 8 & 9
	Select and Design an Intervention With the Community	2 hours	Part 5, session 10.1
	Process the Meeting With the Community	30 min.	Part 5, session 10.2
7	**Site Visits**		
8	**Presentation Skills Training and Principles of Adult Learning**	2.5 hours	Part 5, sessions 12.1–12.4
	Design and Deliver a Health Talk	20 min. per Trainee	Part 5, session 12.5
9	**Plan and Carry out the Intervention With the Community**	2 hours	Part 5, sessions 10.1–10.2
10	**Monitoring and Evaluating an Intervention**	80 min.–2 hours	
	Meet With the Community to Discuss Monitoring and Evaluating the Intervention	30–60 min.	Part 5, sessions 11.1–11.4
	Report out on What Worked and Didn't Work in the Interventions	1–2 hours	
	Lessons Learned: Reflections on the Entire Training Experience/Process	1–2 hours	

PART ONE:
CHILD HEALTH –
COUNTRY OVERVIEW

INTRODUCTION

This section introduces the big picture of child health in-country and in the developing world. It also examines the impact of culture on health beliefs and values.

SUMMARY OF SESSIONS

SESSION 1: Overview of Child Health Issues In-Country contains an outline of a discussion about child health care issues on a national basis. The content of the outline mirrors the way Trainees will gather information in Part Four (i.e., looking at assets, child health problems, and factors affecting those problems). The outline also includes discussion of health care systems in-country, the Peace Corps project plan, the role of the Volunteer, and the role gender plays in the health care system in-country.

SESSION 2: Common Causes of Child Mortality in Developing Countries identifies the most common conditions causing child mortality in developing countries and gives worldwide statistics. It then compares these statistics to the existing causes of child mortality in-country.

SESSION 3: American and Host Country Health Beliefs applies key cross-cultural concepts to health-related attitudes and behaviors. It helps the Trainees understand their health-related beliefs and values as Americans and compare these to values of the host country nationals (HCNs).

All Trainees working in health need a session on traditional health beliefs and practices in-country (to be designed in-country and not included in this manual). The session on **American and Host Country Health Beliefs** discusses cultural values, but not specific in-country practices. This session serves as a good introduction to, and should be done in conjunction with, a session on beliefs and practices. The Trainees need to look at the issues surrounding health beliefs from both perspectives.

All Trainees working in health need a session on traditional health beliefs and practices in-country.

WHEN SHOULD THESE SESSIONS BE DONE?

Every pre-service training will have a session giving an overview of the child health issues and Volunteer program in-country. This session should be done at the beginning of training. The session on common causes can be done as a way of introducing the overview session (this would capture the Trainees' interest) or as a separate short session.

The session on American and Host Country Health Concepts can be done either in the beginning or as an introduction to the sessions in **Understanding the Setting**, p. 127, or along with a session on traditional health beliefs and practices.

SESSION PLAN

PART ONE–SESSION 1: OVERVIEW OF CHILD HEALTH ISSUES

OVERVIEW

This session gives a broad overview of the child health issues on a national level and introduces the health problems or issues in the country, the causes or factors affecting child health conditions, and the assets that exist to address these problems. It sets the basis for the entire training program and covers such important topics as the project plan, the role of the Volunteer, and working with counterparts.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain country-specific information about child health issues and current activities.
2. Explain how the Peace Corps project fits in with what is already happening in child health in the country.

TIME

1.5 hours

MATERIALS

Handouts:

- List of resource people, organizations, and/or contacts including addresses, and phone numbers.
- An organizational chart showing the national, local, formal/informal health care systems in-country and how they are linked (or not linked).
- The country-specific Peace Corps health project plan.
- *Common Causes*

STAFF

The APCD/Health should lead, or at least participate in, this session. Alternatively, the APCD may choose to cover these topics separately, but should be present during this session if possible, to point out the linkages between the national health care issues and the Peace Corps program.

PREPARATION

Meet with the APCD and/or guest speaker in advance to go over the goals and objectives of the session. Prepare the speakers by giving them a presentation outline (see next page) and by informing them about the educational level and background of the Trainees and the types of questions they may have. Make sure the speaker knows what has and has not been covered by other sessions (or what will be covered in future sessions) to avoid too much repetition of information. Encourage the speaker to use good presentational skills (presentational voice, handouts, visual aids, interactive training activities, etc.). Some ideas for the presentation could include:

1. A slide show
2. Overhead projections that contain bullets of the above points
3. A true/false questionnaire using statistics

DELIVERY

STEP 1. Prepare the Trainees by giving them a brief description of who the presenters are, what the topic is, what they should expect to get out of this session, and how it links with other sessions. Brainstorm very briefly the kinds of questions they may have.

STEP 2. Have Trainees complete the handout *Common Causes.*

STEP 3. Introduce the speaker (and/or APCD) and explain that this person will be giving a broad overview of the child health issues in this country. See attached outline.

STEP 4. Lecture by guest speaker (and/or APCD).

STEP 5. When the lecture is finished ask if there are any questions and go over the main points of the session. Discuss briefly how the information presented fits into the overall training design and relates to their work as Volunteers.

OVERVIEW OF THE CHILD HEALTH CARE ISSUES ON A NATIONAL BASIS

— OUTLINE FOR THE GUEST SPEAKER —

This session should be done by the APCD/Health, Ministry of Health (MOH) personnel, and/or other appropriate in-country resource people. The presentation should include a brief description of the following:

1. Health problems in-country[1] (include statistics)

2. Causes or factors affecting child health problems
   - a) Biological: diseases in-country
   - b) Physical environment: water, sanitation, household environment
   - c) Socioeconomic: poverty and economic security
   - d) Cultural: beliefs about health; gender differences in child care of boys and girls

3. The assets being used to solve the problems
   - a) People who are involved in giving health care.[2] (Distribute the handout of resource people or contacts.)
     - (1) Health workers
     - (2) Traditional birth attendants
     - (3) District and community leaders (formal and informal)
     - (4) Traditional healers
     - (5) Nongovernmental organizations (NGOs)/Private voluntary organizations (PVOs)
     - (6) Women's groups
   - b) Describe the national, local, formal/informal health care systems in-country and explain what is being done in the following settings. (Distribute the handout of the organizational chart.)
     - (1) Communities
     - (2) Home
     - (3) Clinics
   - c) Peace Corps
     - (1) The project plan (distribute handout)
     - (2) The role of the Volunteer
     - (3) Working with counterparts

---

[1] Include pertinent gender and development (GAD) issues, such as differences that may exist between male and female child health problems and why.

[2] Include pertinent GAD issues such as the predominant gender of health workers, traditional birth attendants, community leaders, and traditional healers. Are there specific reasons for the gender roles?

SESSION PLAN

PART ONE–SESSION 2:
COMMON CAUSES OF CHILD MORTALITY

OVERVIEW

This exercise identifies the most common conditions causing child mortality in developing countries. This knowledge helps Trainees focus their attention on these key areas as they go about their work in their communities. Trainees want to know the statistics for the host country.

OBJECTIVES

By the end of the session Trainees will be able to:

1. Describe the most common child health problems in developing countries and in their host country.

2. Describe how their work fits into the context of the bigger child health picture.

TIME

15–20 minutes

MATERIAL

Handout: *Common Causes*

PREPARATION

Collect statistics on the five most common conditions causing child mortality in-country. If the data is not available, try to find out whether these five conditions are major causes of child mortality in-country. If there is a major condition in-country that is not on this list, be ready

53

to tell Trainees about it. Also be ready to tell Trainees about any conditions on the list that are *not* a key cause in-country.

DELIVERY

STEP 1. Explain the purpose of the session and introduce the exercise.

STEP 2. Distribute the handout and have Trainees complete the exercise on their own.

STEP 3. Go over the answers (below). Explain any differences in these answers—whether in ranking, percentages, or conditions—for the host country. Ask Trainees if they are surprised by any of the answers.

ANSWERS The ranking[1], worldwide, is as follows:

1. Malnutrition (56%)
2. Acute respiratory infections (33.7%)
3. Diarrhea (24.7%)
4. Measles (9.5%)
5. Malaria (7.7%)

The conditions and ranking for your country are:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

STEP 4. Ask Trainees to think about possible combinations of these conditions. Which conditions are likely to occur together, and which ones are likely to be causes of or contribute to others? Why might it be important to consider this question?

STEP 5. Close the session by repeating that as these are the most likely causes of child mortality in-country, then health efforts will most likely be aimed at these conditions.

---

[1] ***Bulletin of The World Health Organization***, 1995, 73(6), pp. 735–740.

TRAINEE HANDOUT

COMMON CAUSES

Recent data suggests that "at least 70 percent of all childhood mortality" in developing countries is the result of five major conditions (***Bulletin of the World Health Organization***, 1995, 73 (6), pp. 735–740). These five conditions are listed below in no particular order. Put a "1" next to the condition you think is the greatest cause of child mortality, a "2" for second most common cause, etc. Then take a guess at the percentage of deaths associated with each condition. (The total of percentages will be more than 100 because many deaths are caused by a combination of these conditions.)

Condition	**% of deaths associated with this condition**
_____ Diarrhea	_____%
_____ Measles	_____%
_____ Acute respiratory infections	_____%
_____ Malnutrition	_____%
_____ Malaria	_____%

SESSION PLAN

PART ONE–SESSION 3:
AMERICAN AND HOST COUNTRY HEALTH BELIEFS

OVERVIEW

To work effectively in health care Trainees need to be aware of the fundamental health beliefs of the local people. This knowledge will help Trainees understand health-related attitudes and behaviors of host country nationals (HCNs), and how HCNs may regard the health-related behaviors and attitudes of the Volunteer.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Identify key American and HCN cultural differences regarding health beliefs and practices.
2. Examine the consequences of these differing beliefs for Volunteers working in child health in the host country.

TIME

30–45 minutes

PREPARATION

This is an important cross-cultural session and should be linked to other sessions. The content relates "Fundamentals of Culture–Comparing American and Host Country Views," Chapters 3–5 in **Culture Matters Workbook**. Work with the cross-culture trainer to make linkages and appropriately place this session in the schedule.

MATERIALS

Flip-chart paper, marking pens

Handout: *American and Host-Country Health Beliefs: Continuum and Continuum Notes*

DELIVERY

STEP 1. Explain that this session will help them to consider American and HCN beliefs concerning four basic health questions:

- locus of control
- attitude toward suffering
- origin of disease
- response to disease

List on flip-chart. Explain that there are various possible views on these topics. The two extremes on each of these questions are described in the handout they will receive.

Explain that Trainees in groups will read the two definitions for each question and then put a mark (U.S.) on the line where they think the American position is in general on this question. They should then do the same for the host country position. Give an example on a flip-chart. Tell Trainees not to worry about generalizing; an individual's view may be different from their culture's view, and within one culture there may be regional or ethnic variations. (Alternatively, have HCNs who are present do this for their culture.)

STEP 2. Divide Trainees into groups and distribute the handouts.

STEP 3. Discuss their group work. Ask Trainees what it means if the U.S. mark is on one side and the HCN mark on the opposite side. Point out that where a culture's mark appears, the people in that culture (in general):

- think that this belief is right, natural, normal, and good;
- think this is how everyone sees this matter, or should see it; and
- judge other people's behavior from this point of view.

STEP 4. In those cases where the U.S. mark and the HCN mark are on opposite sides, ask Trainees how someone on one side would judge the behavior of someone on the other side. Discuss what behaviors they may see that would indicate some of these beliefs.

STEP 5. Ask Trainees if this exercise has helped explain any behavior they have noticed in-country thus far. What is the importance of this information to their work?

AMERICAN AND HOST COUNTRY HEALTH BELIEFS:

CONTINUUM

Internal ________________________________ External

Suffering
Is Normal ______________________________ Suffering
Is Abnormal

Physical ________________________________ Spiritual

Rituals, Etc. ___________________________ Medicine, Etc.

TRAINEE HANDOUT
PAGE 2 OF 3

AMERICAN AND HOST COUNTRY HEALTH BELIEFS

LOCUS OF CONTROL

Internal. Fate is assumed to play little or no role in people's lives; people are masters of their destiny and can control or at least influence external forces. There are few givens in life, few things that have to be accepted and cannot be changed. Life is what I do. Activism.

External. Fate plays a major role. People believe they have limited control over their destiny or over external forces. Many things in life have to be accepted and cannot be changed. Life is something that happens to me. Stoicism.

ATTITUDE TOWARD SUFFERING

Pain, suffering, disease—misfortune—are a natural part of life. Some disease, etc. is to be expected, is inevitable. You do what you can, but you can only do so much. Some suffering just has to be accepted and endured. If you're sick, it may be God's will.

Pain and suffering are not normal or natural. They can be prevented and eliminated. Disease does not have to be accepted; if one doctor/ medicine is not effective, then another one will be. If you're sick, you should do something.

ORIGIN OF DISEASE

Disease is a physical phenomenon. Some "thing"—a germ, virus, bacteria—has entered the body and caused it to malfunction. Or some other physical cause—pollution, smoke, insects, an external trauma—has damaged the body.

Disease can be a physical, emotional, or spiritual phenomenon. It may be retribution for something bad you did; it may be the evil eye; it may be contact with unwholesome forces of one type or another. Or just fate.

RESPONSE TO DISEASE

Prayer, visiting spiritual healers, performing various rituals, such as bathing with certain ointments or in sacred places. Eating or drinking special herbs or potions. Making offerings at the temple. Keeping external "forces" happy or under control.

Taking the medicine or other treatment that will neutralize the physical cause. Or eliminating the external physical factors that are the cause. Also keeping the body healthy through proper diet, exercise, regular checkups.

0 60

771 61

TRAINEE HANDOUT
PAGE 3 OF 3

THE VALUES OF CONTINUUM

1. CHANGE .... TRADITION
2. PERSONAL CONTROL OVER ENVIRONMENT .... FATE
3. TIME AND ITS CONTROL .... HUMAN INTERACTION
4. EQUALITY .... RANK/STATUS/HIERARCHY
5. INDIVIDUALISM/PRIVACY .... GROUP'S WELFARE
6. SELF HELP .... BIRTHRIGHT/INHERITANCE
7. COMPETITION .... COOPERATION
8. FUTURE ORIENTATION .... PAST ORIENTATION
9. ACTION/WORK ORIENTED .... BEING ORIENTED
10. INFORMALITY .... FORMALITY
11. DIRECTNESS/HONESTY .... INDIRECTNESS/FACE SAVING
12. PRACTICALITY/EFFICIENCY .... IDEALISM
13. MATERIALISM/ACQUISITIVENESS .... SPIRITUALISM

(BASED ON KOHL 13 VALUES)

PART TWO: FUNDAMENTALS OF CHILD HEALTH

INTRODUCTION

This section is a short course in the basics of child health for Trainees with little or no background in the field. Most Volunteers involved in child health work are not—and do not need to be—experts in the subject, but they do need to be familiar with certain key concepts and topics. The purpose of these sessions is to provide Trainees with those basics.

For most Peace Corps child health programs this information will provide Trainees with sufficient knowledge and skills to carry out their duties. In some cases, depending on the Peace Corps program and Volunteer assignment, generalist Trainees will need more information. Accordingly, you and the APCD will need to review the contents of this section against Volunteer assignments and skill requirements to determine what additional topics might need to be covered.

You should note that several of the most important exercises in this section depend on Trainees having in their possession the following supplementary texts:

1. ***Facts for Life: A Communication Challenge***. Peter Adamson with Glen Williams. (UNICEF) 1990. 78 pp. [ICE # HE231]

2. ***Assess and Classify the Sick Child Age Two Months Up to Five Years***. Integrated Management of Childhood Illnesses, Module 14.B. Prepared by WHO's Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) and UNICEF 1995. 150 pp. [ECE # R0111]

3. ***Integrated Management of Childhood Illnesses (IMCI) Chart***. Integrated Management of Childhood Illnesses. Prepared by WHO's Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) and UNICEF 1995. 36 pp. [ICE # HE347]

4. ***Counsel the Mother***. Integrated Management of Childhood Illnesses, Module 14.E. Prepared by WHO's Division of Diarrhoeal and Acute Respiratory Disease Control (CDR) and UNICEF 1995. 63 pp. [ICE # R0110]

A copy of these are included in the package accompanying this manual for your reference. Additional copies for the Trainees may be obtained from ICE.

SUMMARY OF SESSIONS

Ideally, you should present the sessions in the order in which they appear. Certainly, the information contained in Session 1, **Facts for Life** (the content of Session 1) is an essential starting point and should be presented first.

SESSION 1: **The Child and the Mother** is a diagnostic test to determine how much individual Trainees already know about child health.

SESSION 2: **The Healthy Child** prompts Trainees to look at what the mother and the community are already doing to promote healthy children. It is important for Trainees to build on this when looking at problems, and potential solutions and designing interventions.

SESSION 3: **Childhood Diseases and Their Symptoms** is a basic introduction to the most common child health problems and their outward signs and symptoms.

SESSION 4: **Assessing the Sick Child: An Integrated Approach** teaches basic assessment skills. It builds on previous sessions and requires the Trainees to apply what they know about childhood diseases and symptoms to a series of hypothetical patients.

SESSION 5: **Checking the Child's Immunization Status** familiarizes Trainees with the importance of, and the steps to monitoring, immunizations.

SESSION 6: **Determining Weight for Age** teaches this skill, using the WHO prototype.

SESSION 7: **Counseling the Mother** introduces Trainees to the concepts of breast-feeding and complementary foods using WHO resource materials.

SESSION 8: **Water and Sanitation Diseases and their Prevention** familiarizes Trainees with the relationship between water and sanitation-related diseases and their causes.

WHEN SHOULD THESE SESSIONS BE DONE?

You should present these sessions as early as possible during PST. Trainees with limited health background are understandably anxious about their lack of knowledge and experience and may grow more anxious if you try to present other sessions first. Also the rest of the manual builds on the information covered in these sessions.

SESSION PLAN

PART TWO–SESSION 1:

THE CHILD AND THE MOTHER

OVERVIEW

The purpose of this session is to start a discussion about child health issues in-country. The quiz pre-tests the Trainees' knowledge of essential child health information in developing countries, and provides the opportunity to give the facts about effective health care. This session lays the foundation for learning about the fundamentals of child health and for analyzing child health issues and practices in the community.

There is broad agreement among medical experts on the essential child health information that all families have a right to know. ***Facts for Life: A Communication Challenge*** brings that information together. It is the most authoritative expression, in plain language, of what medical science now knows about practical, low-cost ways of protecting children's lives and health. It is essential reading for all Peace Corps Volunteers who are working in the child health field, not only for their own education, but also for use in any health communication program that they may be involved in or develop.

OBJECTIVES

By the end of the session Trainees will:

1. Assess the level of their knowledge about child health.
2. Be motivated to learn more about child health.

TIME

30–60 minutes

MATERIALS

Facts for Life: A Communication Challenge for each Trainee. This booklet may be obtained from your local UNICEF office. If they are not available either through UNICEF or the in-country Peace Corps office, they may be ordered through ICE at Peace Corps headquarters. (ICE # HE 231)

Handout: *Quiz: The Child and the Mother*

DELIVERY

STEP 1. Explain the purpose of this session. Distribute the quiz, *The Child and the Mother*, and have them complete the quiz. Tell them not worry if they don't know the answers to some of the questions.

STEP 2. Discuss the answers. Remember to put the answers into the country context and clarify any differences between the health policies and practices in-country and those presented in the answers which are based on the booklet, ***Facts for Life***. (You may wish to refer to the appropriate sections in the booklet as you go along.)

STEP 3. Distribute the booklet, ***Facts for Life***. Explain its content and how it can be used as a primary resource in their work as Peace Corps Volunteers. Mention that the answers to the quiz are contained in this booklet along with more detailed explanations to the answers.

ANSWERS

1. **a**. Spacing births at least two years apart.
2. **b**. Six months old
3. **a**. First year of life
4. **c**. Tetanus
5. Is the child eating frequently enough?
   Do the child's meals have too little energy in them?
   Is the child frequently ill?
   Has the child been refusing to eat when ill?
   Is the child getting enough vitamin A?
   Is the child being bottle-fed?
   Are food and water being kept clean?
   Are feces being put into a latrine or buried?
   Does the child have worms?
   Is the child alone too much?
   (See pages 30 and 31 in ***Facts for Life*** for further explanations.)

6. Breast milk; green leafy vegetables; orange-colored fruits and vegetables.
7. Give the child breast milk alone for the first six months of life, then introduce other foods; make sure the child is fully immunized before the age of one year; always use latrines and keep hands, food, and kitchen clean.
8. True
9. False
10. False
11. True
12. True
13. **d.** Measles
14. Breast-feeding, not bottle-feeding
    Feeding a child well
    Giving a child Vitamin A rich foods
    Completing immunizations before the age of one
    Avoid overcrowding which helps spread coughs and colds
    (See page 57 in ***Facts for Life*** for further explanations.)
15. True
16. True
17. Disposing of feces properly
18. Stagnant water can collect
19. Filling in or draining areas where water collects
    Covering overhead tanks or water collection tanks
    Drying out rice fields between crops
    Introducing mosquito larvae-eating fish into rice fields
    Regular clean-up of the neighborhood
20. About 30%; three years old. (This may change as new treatments become available.)

TRAINEE QUIZ

THE CHILD AND THE MOTHER

1. The health of both women and children can be significantly improved by: (check only one)

☐ a. Spacing births at least two years apart

☐ b. Avoiding pregnancies before the age of twenty

☐ c. Limiting the number of pregnancies to six

☐ d. All of the above

2. Infants need other foods, in addition to breast milk, when they are about: (check only one)

☐ a. Three months old

☐ b. Six months old

☐ c. Nine months old

3. In developing countries, all immunizations should be completed in the: (check only one)

☐ a. First year of life

☐ b. Second year of life

☐ c. Third year of life

4. Every woman of childbearing years should be immunized against: (check only one)

☐ a. Tuberculosis

☐ b. Hepatitis

☐ c. Tetanus

☐ d. Measles

5. If a child under the age of three is not gaining weight, but is eating good food, there are ten important questions you should ask the mother. List five of these questions.

   1. ______________________________
   2. ______________________________
   3. ______________________________
   4. ______________________________
   5. ______________________________

6. List three sources of Vitamin A:

   1. ______________________________
   2. ______________________________
   3. ______________________________

7. It is important to protect a child's growth by preventing illness. List three ways a mother can do this:

   1. ______________________________
   2. ______________________________
   3. ______________________________

8. True or False: It is safe to immunize a child suffering from a minor illness or malnutrition.

9. True or False: If a girl or woman has been vaccinated three times against tetanus, then she is protected against the disease throughout her childbearing years.

10. True or False: A child with diarrhea should not be given any food or drink while the diarrhea lasts.

11. True or False: Most medicines for diarrhea are either useless or harmful.

12. True or False: Most medicines sold for coughs and colds are useless or harmful.

13. There is one vaccine that can protect a child against this cause of diarrhea. Which one is it?

- ☐ a. Polio
- ☐ b. Diphtheria Pertussis Tetanus (DPT)
- ☐ c. Tuberculosis
- ☐ d. Measles

14. List five things a mother can do to prevent her child from getting pneumonia.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

15. True or False: Washing your hands with soap and water is essential in preventing disease.

16. True or False: The feces of babies and young children are more dangerous than those of adults.

17. What is the single most important action that families can take to prevent the spread of germs.

18. Mosquitoes breed wherever ____________________

19. What can a community do to prevent mosquitoes from breeding? (List five ways)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

20. Women with HIV infection have a ______ % chance of giving birth to a baby who will also be infected with HIV. Most babies infected with the virus will die before they are ______ years old.

Session Plan

Part Two–Session 2:
The Healthy Child

Overview

A major focus of community analysis is looking at available assets. One asset is what is working well in the home, clinic, or community. In this session the Trainees will discuss the healthy child and look at what the mother and the community may already be doing to promote a healthy child.

Objectives

By the end of the session the Trainees will be able to:

1. Explain the concept of the healthy child as one of the community's assets.
2. Explain why it is important to find out what is working well in a community, in addition to what is not working, when conducting assessments.
3. Describe basic child health information.

Time

20–30 minutes

Material

Handout: *The Healthy Child*

DELIVERY

STEP 1. Explain the purpose of this session. Distribute the *Healthy Child* handout. Ask the Trainees to look at Part One of this exercise, read through the list in the left hand column of signs and symptoms of the child who is ill, and then look in the right hand column for the signs that signify a healthy child. Ask the Trainees if they have anything to add to the lists and if they have any questions.

STEP 2. Now that they have a picture of a healthy child, ask the Trainees to complete Parts Two and Three. Give them five minutes.

STEP 3. Go through the answers for Part Two. Begin by asking how many checked **a** Ask them why they checked it. Ask if there are any questions about why this is important. Continue down the list in the same manner. Discuss the health points being made by each answer.

ANSWERS:

a. Mother boils the child's drinking water.

d. Mother feeds the child tangerines, green leafy vegetables, pumpkin, and squash.

g. Mother has had her child vaccinated against tuberculosis.

j. Mother gives her child roasted corn, boiled potatoes and other snacks in between meals.

k. Mother feeds her child rice and oily curries.

l. Mother feeds her child an egg once a week when she can get it.

n. Mother bathes her child every day down at the river.

o. Mother gives her child worm medicine when the child's stomach is bloated.

p. Mother sleeps with the child out of doors when the weather is hot.

q. Mother washes her hands before preparing food.

Discussion points:

1. Note that **g**, **o**, and **p** are a bit tricky: A child may be immunized against TB, but what about the other immunizations (tetanus, diphtheria, whooping cough, and measles)?

   A child with a bloated stomach could have worms, but it could also be a symptom of malnutrition.

If sleeping indoors means the child is sleeping in a crowded room where they may be exposed to respiratory infections, then sleeping outdoors is healthy. But it depends on the country. If there is malaria in-country and the child is sleeping outdoors (or indoors) without a mosquito net, then they could be at risk for being bitten by malaria-bearing mosquitoes.

2. The Trainees may also have checked **i** because it depends on the diet of the adults and whether the child is old enough to chew and digest this food.
3. Some behaviors are neither detrimental nor beneficial. For example, **h**—the mother goes to the temple when her child is sick. From a western medical point of view, this activity has little relevance to the health of a child, but a mother may view this activity as essential to the health of her child according to her cultural beliefs and customs.

STEP 4. Go through the answers for Part Three, as above.

ANSWERS:

a. The community has an ongoing immunization program through the hospital or clinic.

d. The community has had a malaria eradication program.

e. The community has installed a drinking water system.

f. The community has a mother's club with programs such as planting kitchen gardens.

g. There is a small clinic in the community.

Discussion points:

1. Again, **e** can be a trick question. If the source for the water system is a river which is polluted, then it could be detrimental to a child's health.
2. **b** and **c** do not directly impact on a child's health, but such community/social activities as market places and festivals can be a sign of a healthy community. With regard to **b**, sweets are often sold in the open without wrapping and there many be many flies in the market landing on the sweets. Flies are often carriers of disease and a child eating these sweets could get sick.

TRAINEE HANDOUT
PAGE 1 OF 3

THE HEALTHY CHILD

PART I: IDENTIFYING THE HEALTHY CHILD

The following table describes the signs and symptoms of an ill child and the corresponding signs of a healthy child. Do you have anything to add to either of the columns below?

Signs and Symptoms of Illness	**The Healthy Child**
1. Diarrhea	1. Normal stools, no diarrhea
2. Cough or difficulty breathing, runny nose	2. No cough, normal breathing, no runny nose
3. Fever	3. No fever
4. Ear infection, ear drainage	4. No apparent ear infection
5. Looks very thin and wasted	5. Looks robust and healthy for age
6. Looks lethargic, eyes are sunken	6. Looks bright and alert, eyes not sunken
7. Eyes are red or look infected	7. Eyes are normal, no pus, no redness
8. Skin has a rash	8. No apparent rash
9. Has sores on its body	9. Skin is free of sores, looks healthy
10. Is irritable and crying all the time	10. Is smiling and happy/good natured
11. No appetite, eating poorly	11. Normal appetite, eating well
12. Drinking poorly or thirsty all of the time; difficulty with breast-feeding	12. Drinks or breast-feeds normally
13. Stomach is bloated	13. Stomach looks normal for age
14. Feet are swollen	14. Feet look normal

TRAINEE HANDOUT
PAGE 2 OF 3

THE HEALTHY CHILD

PART II: WHAT THE MOTHER IS DOING RIGHT

Below is a list of activities a mother may do during any given day. Check those activities that contribute to having a healthy child.

☐ a. Mother boils the child's drinking water.
☐ b. Mother feeds the child raw fruits and vegetables.
☐ c. Mother bottle-feeds her child.
☐ d. Mother feeds the child tangerines, green leafy vegetables, pumpkin and squash.
☐ e. Child sleeps in a common room.
☐ f. Mother cooks over a smoky fireplace.
☐ g. Mother has had her child vaccinated against tuberculosis.
☐ h. Mother goes to the temple when her child is sick.
☐ i. Mother feeds her child whatever the adults are eating.
☐ j. Mother gives her child roasted corn, boiled potatoes, and other snacks in between meals.
☐ k. Mother feeds her child rice and oily curries.
☐ l. Mother feeds her child an egg once a week when she can get it.
☐ m. Mother stops feeding her child when he has diarrhea.
☐ n. Mother bathes her child every day down at the river.
☐ o. Mother gives her child worm medicine when the child's stomach is bloated.
☐ p. Mother sleeps with the child out of doors when the weather is hot.
☐ q. Mother washes her hands before preparing food.

TRAINEE HANDOUT
PAGE 3 OF 3

THE HEALTHY CHILD

PART III: HOW THE COMMUNITY IS PROMOTING HEALTHY CHILDREN

Below is a list of activities in a certain community. Check all those activities which could contribute to having healthy children in this community.

☐ a. The community has an ongoing immunization program through the hospital or clinic.

☐ b. The community has a large open market place where they sell many sweets, fruits, vegetables, meat, etc.

☐ c. The community holds a large festival every year where there is dancing, music, and lots of activities.

☐ d. The community has had a malaria eradication program.

☐ e. The community has installed a drinking water system.

☐ f. The community has a mothers' club with programs such as planting kitchens gardens.

☐ g. There is a small clinic in the community.

☐ h. The community has mass media campaigns advertising powdered milk.

SESSION PLAN

PART TWO–SESSION 3: CHILDHOOD DISEASES AND THEIR SYMPTOMS

OVERVIEW

Volunteers who are working with mothers and children, either in a clinic, home, or community setting, will encounter sick children. Whether Volunteers are working in a health care facility or doing health education in the community, they need to have a basic understanding of childhood diseases. In this session the Trainees learn how to identify some of the signs and symptoms of these diseases.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Present common childhood diseases and their symptoms.
2. Associate symptoms with common diseases.

TIME

20 minutes

MATERIALS

Handout: *Childhood Diseases and Their Symptoms*

DELIVERY

STEP 1. Explain the purpose of the session.

STEP 2. Explain that the purpose of the handout is to discover what they know about childhood diseases and their symptoms. Distribute the handout *Childhood Diseases and Their*

Symptoms and ask the Trainees to match the signs and symptoms that describe the childhood diseases in the right-hand column. Tell them to write the number of the sign or symptom in the blank next to the disease it describes. Give them five minutes. Trainees should not expect to know all the answers; the exercise will demonstrate what they do not know and make them aware of what they need to learn.

STEP 3. Review the answers with the Trainees.

ANSWERS:

Signs and Symptoms	Diseases
1. Fever and a generalized rash	a. 12 Intestinal parasites
2. Visible severe wasting	b. 7 Kwashiorkor
3. Palmar pallor	c. 9 Malaria
4. Restless, irritable, sunken eyes	d. 1 Measles
5. Blood in stool	e. 11 Conjunctivitis
6. Fever, difficulty breathing	f. 10 Meningitis
7. Edema of both feet	g. 2 Marasmus
8. Ear pain, pus draining from ear	h. 5 Dysentery
9. Fever for two days	i. 6 Pneumonia
10. Fever, vomiting, stiff neck	j. 3 Anemia
11. Pus draining from the eye	k. 8 Acute ear infection
12. Anemia	l. 4 Dehydration

TRAINEE HANDOUT

CHILDHOOD DISEASES AND THEIR SYMPTOMS

Match the following signs and symptoms with the disease they best describe. Write the number of the sign or symptom in the blank next to the disease.

Signs and Symptoms	**Diseases**
1. Fever and a generalized rash	a. _______ Intestinal parasites
2. Visible severe wasting	b. _______ Kwashiorkor
3. Palmar pallor	c. _______ Malaria
4. Restless, irritable, sunken eyes	d. _______ Measles
5. Blood in stool	e. _______ Conjunctivitis
6. Fever, difficulty breathing	f. _______ Meningitis
7. Edema of both feet	g. _______ Marasmus
8. Ear pain, pus draining from ear	h. _______ Dysentery
9. Fever for two days	i. _______ Pneumonia
10. Fever, vomiting, stiff neck	j. _______ Anemia
11. Pus draining from the eye	k. _______ Acute ear infection
12. Anemia	l. _______ Dehydration

SESSION PLAN

PART TWO–SESSION 4:
ASSESSING THE SICK CHILD: AN INTEGRATED APPROACH

OVERVIEW

"Every year some 12 million children die before they reach their fifth birthday, many of them during the first year of life. The majority (70%) of these deaths are due to diarrhea, pneumonia, measles, malaria or malnutrition—and often to a combination of these conditions. In addition to this substantial mortality, these conditions typically account for three out of four sick children seeking care at a health facility. A single diagnosis for a sick child is often inappropriate because it identifies only the most apparent problem and can lead to an associated and potentially life-threatening condition being overlooked. In addition, the signs and symptoms of several of the major childhood diseases overlap substantially. Therefore, the child health programs should address the sick child as a whole and not a single disease." (***Bulletin of the World Health Organization***, 1995, 73 (6), pp. 735-740)

The majority of Peace Corps Volunteers will not be—and indeed should not be—diagnosing and treating sick children. But if a Volunteer is assigned to a health care facility or is working with mothers and children in the community, she/he needs to have a basic understanding of childhood illnesses and their manifestations. In this session the Trainees learn more about these illnesses through case studies and discuss their role in dealing with these types of situations.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe the concepts of the integrated approach to child health assessment.
2. Apply the integrated approach to health assessment.
3. Assess the condition of sick children.

TIME

60–90 minutes

MATERIALS

Handouts:

- *The Integrated Approach to Child Health*
- *Case Studies for the Integrated Approach to Assessing the Sick Child*
- *Assess and Classify the Sick Child Age Two Months Up to Five Years*
- *Integrated Management of Childhood Illnesses (IMCI) Chart*

PREPARATION

Prior to this session distribute the WHO training module ***Assess and Classify the Sick Child Age Two Months Up to Five Years***. Explain to them that this is one of seven modules of a whole training package developed by the World Health Organization for training local health professionals in the assessment and treatment of children under five. As a pre-session assignment, ask the Trainees to read sections 1.0 through 7.0 and remind them to bring this booklet with them to this session.

Find out ahead of time what the country is doing, if anything, with the *Integrated Management of Childhood Illnesses (IMCI)* so you can discuss the in-country program with the Trainees.

You may wish to put the quote from the ***Bulletin of the World Health Organization*** (found in the overview above) on a flip chart prior to this session or hand it out at the beginning of the session during Step 1 when you explain the purpose of this session.

DELIVERY

STEP 1. Explain the overview and purpose of this session. Emphasize that the Volunteer's role is not to diagnose and treat childhood diseases (unless it is part of their job description), but to have a basic understanding of the common childhood diseases they may be encountering in their work.

STEP 2. Ask the Trainees to pair up with the person next to them. Explain that one Trainee in the pair will play the role of a Volunteer and the other will play the role of a mother or father. Distribute the handout which consists of the role of the mother and the assessment tool for the Volunteer.

Explain that this tool is a chart on how to assess and classify sick children so that signs of disease are not overlooked.

STEP 3. The Trainees playing the role of Volunteers should read the case studies. Meanwhile, the Trainees playing the mothers/fathers should be given the following instructions:

a) Read the case study to yourself.

b) When asked "what are the child's problems?" only tell the Volunteer the main complaint as written under "Tell the Volunteer..."

c) Do not give any other information unless asked by the Volunteer.

d) Any information not included in the case study means that your child does not have that symptom or problem, so simply answer "no, my child does not have ...."

STEP 4. Reverse Step 3, having the mothers and fathers read while you brief those Trainees playing the Volunteer role.

a) Begin by greeting the mother/father appropriately.

b) Ask the mother how old her child is.

c) Ask what are the child's problems.

d) Go through all the questions on the left side of the form. Check off or circle the answers on your assessment tool. Skip the questions on immunization status and assessing the child's feeding. These will be covered later on.

e) For this exercise, wherever the form says to look or listen or do something, simply ask the mother the question. In real life, you would be able to observe or do these things.

f) You may use the booklet ***Assess and Classify the Sick Child Age Two Months Up to Five Years*** during this exercise to help you.

g) Write your assessment(s) under the "classify" column.

STEP 5. Assign pairs different case studies. Have them begin. Circulate and assist as necessary. Have pairs keep the same roles for two cases. As necessary, stop and discuss any difficulties they are having.

STEP 6. When they are finished with two cases, ask the Trainees to switch roles. Review what to do in each role. Have them do two more cases.

STEP 7. Ask each pair to read their case studies out loud to the group and give their assessment. Have them explain how they arrived at their decision. Alternatively, if it is a large group, form several groups of three to four pairs to do this.

STEP 8. If you plan on doing the session **Child Health Assessment: A Practicum**, p. 180, from this manual, tell the Trainees that they will have more opportunities to use this tool with mothers in the health care setting or home during the information gathering phase of their training.

STEP 9. Discuss how the Volunteers in their assignment would use this approach to assess and classify the sick child. If there is an IMCI program in-country, inform the Trainees about it and discuss their role, if any, in working with IMCI.

Answers to the Case Studies:

1. Pneumonia
2. Danger sign + severe pneumonia
3. Diarrhea + some dehydration
4. Diarrhea + some dehydration
5. Dysentery (no dehydration)
6. Malaria
7. Measles + high risk for malaria
8. Fever (malaria unlikely)
9. Acute ear infection
10. Marasmus, a form of severe malnutrition
11. Anemia
12. Very low weight for age + diarrhea with some dehydration

TRAINEE HANDOUT

THE INTEGRATED APPROACH TO CHILD HEALTH

"Every year some 12 million children die before they reach their fifth birthday, many of them during the first year of life. The majority (70%) of these deaths are due to diarrhea, pneumonia, measles, malaria or malnutrition—and often to a combination of these conditions. In addition to this substantial mortality, these conditions typically account for three out of four sick children seeking care at a health facility. A single diagnosis for a sick child is often inappropriate because it identifies only the most apparent problem and can lead to an associated and potentially life-threatening condition being overlooked. In addition, the signs and symptoms of several of the major childhood diseases overlap substantially. Therefore, the child health programs should address the sick child as a whole and not a single disease."

From the ***Bulletin of the World Health Organization***, 1995, 73 (6), pp. 735-740)

TRAINEE HANDOUT
PAGE 1 OF 3

CASE STUDIES FOR THE INTEGRATED APPROACH TO ASSESSING THE SICK CHILD

1. MOTHER OF AZIZ

Your son, Aziz, is 18 months old. He weighs 11.5 kg. He has had a cough for 6 or 7 days and is having trouble breathing. He feels warm, and you think he has a slight fever (37.5 C degrees). Aziz is able to drink fluids; he is not vomiting; he has not had any seizures or convulsions; and he is not lethargic or unconscious. He has fast breathing (41 breaths per minute). He has no chest indrawing or stridor.

You are worried and have brought him to the Peace Corps Volunteer who lives down the street for advice. You tell the Volunteer that Aziz has a cough.

2. FATHER OF WAMBUI

Your daughter, Wambui, is 8 months old. She weighs 6 kg. She has had a cough for 3 days and is having trouble breathing. She is very weak and has a fever (39 C). Wambui will not breastfeed or take anything to drink. She is not vomiting and has not had any convulsions. You observe that she is very lethargic and is non-responsive. She has fast breathing (55 breaths per minute). She has chest indrawing and stridor when she breathes.

You tell the Volunteer that Wambui has a cough.

3. MOTHER OF PANO

Your son, Pano, is 10 months old and weigh 8 kg. He has had diarrhea for 5 days. He has no blood in the stool. He is irritable and you notice that his eyes are sunken. Whenever you offer him water, he drinks eagerly. When you pinch the skin on his abdomen, it goes back slowly.

You tell the Volunteer that Pano has diarrhea.

4. MOTHER OF RANA

Your daughter, Rana, is 14 months old and weighs 12 kg. Her temperature is 37.5 C. She has had diarrhea for 2 days. There is no blood in the stool. Rana has been irritable and drinks eagerly whenever you offer her something to drink. Her eyes are not sunken, and when you pinch the skin on her abdomen, it goes back immediately.

You tell the Volunteer that Rana has diarrhea.

Developed from ***Assess and Classify the Sick Child Age Two Months Up to Five Years***, World Health Organization, 1995.

TRAINEE HANDOUT
PAGE 2 OF 3

CASE STUDIES FOR THE INTEGRATED APPROACH TO ASSESSING THE SICK CHILD

5. FATHER OF ERNESTO

Your son, Ernesto, is 10 months old and weighs 8 kg. His temperature is 38.5 C. He has had diarrhea for 3 days and you noticed blood in his stool. Ernesto is not lethargic or unconscious. He is not restless or irritable. His eyes do not appear sunken. He drinks normally when you offer him water and doesn't seem thirsty. When you pinch the skin of his abdomen, it goes back normally.

You tell the Volunteer that Ernesto has diarrhea.

6. MOTHER OF KAREEM

Your son, Kareem, is 5 months old and weighs 5.2 kg. He feels hot (temperature is 37.5 C). His fever began 2 days ago. He has not had measles within the last 3 months. He does not have a stiff neck, his nose is not runny, and he has no signs suggesting measles. You live in a high risk malaria area and it is the rainy season.

You tell the Volunteer that Kareem feels hot.

7. MOTHER OF ATIKA

Your daughter, Atika, is 5 months old and weighs 5 kg. Her temperature is 36.5 C. She has felt hot on and off for 2 days. She has not had measles within the last 3 months. She does not have a stiff neck or runny nose. Atika has a general rash. Her eyes are red, and you notice she has ulcers in her mouth, but they are not deep or extensive. She does not have pus draining from her eyes nor does she have clouding of the cornea. You live in an area where many cases of malaria occur all year long (high malaria risk).

You tell the Volunteer that Atika feels hot to you.

8. FATHER OF DOLMA

Your daughter, Dolma, is 12 months old and weighs 7.2 kg. Her temperature is 36.5 C. She has felt hot to you for 2 days. She has had diarrhea for 2 to 3 days. You have not noticed any blood in her stool. She has no signs of dehydration. She has not had measles in the last three months. She does not have a stiff neck, runny nose, or generalized rash. There is no malaria in the area where you live.

You tell the Volunteer that Dolma feels hot.

TRAINEE HANDOUT
PAGE 3 OF 3

CASE STUDIES FOR THE INTEGRATED APPROACH TO ASSESSING THE SICK CHILD

9. MOTHER OF DANA

Your daughter, Dana, is 18 months old and weighs 9 kg. Her temperature is 37 C. She has had a discharge coming from her right ear for the last 3-4 days. She does not have ear pain or any tender swelling behind either ear.

You tell the Volunteer that Dana has had discharge coming from her ear.

10. MOTHER OF NADIA

Your daughter, Nadia, is 18 months old and weighs 7 kg. Her temperature is 37 C. You are very worried about Nadia because she looks like skin and bones–she has visible severe wasting. Nadia does not have palmar pallor. Nor does she have edema of both feet.

You tell the Volunteer that you are worried about Nadia because she is very thin.

11. FATHER OF KALISA

Your son, Kalisa, is 11 months old and weighs 8 kg. His temperature is 37 C. He has had a dry cough for 21 days He is breathing 41 breaths a minute and has no chest indrawing or stridor. He has no signs of visible severe wasting. You have noticed that his palms are very pale and appear almost white. There is no edema of both feet.

You tell the Volunteer that Kalisa has had a cough for the last 3 weeks.

12. MOTHER OF ALULU

Your son, Alulu, is 9 months old and weighs 5 kg. His temperature is 36.8 C. He has had diarrhea for 5 days. You have not noticed any blood in the stool. Alulu is not restless or irritable; he is not lethargic or unconscious. His eyes are not sunken. He is thirsty and eager to drink water whenever you offer it to him. When you pinch the skin on his abdomen, it goes back slowly. He looks thin to you, but does not have signs of visible severe wasting. He does not have palmar pallor or edema of both feet.

You tell the Volunteer that you are worried about Alulu's diarrhea.

88

ASSESS AND CLASSIFY THE SICK CHILD
AGE 2 MONTHS UP TO 5 YEARS

ASSESS

ASK THE MOTHER WHAT THE CHILD'S PROBLEMS ARE

- **Determine if this is an initial or follow-up visit for this problem.**
  - **If follow-up visit, use the follow-up instructions on *TREAT THE CHILD* chart.**
  - **If initial visit, assess the child as follows:**

CHECK FOR GENERAL DANGER SIGNS

ASK:

- Is the child able to drink or breastfeed?
- Does the child vomit everything?
- Has the child had convulsions?

LOOK:

- See if the child is lethargic or unconscious.

A child with any genral danger sign needs URGENT attention; complete the assessment and any pre-referral treatment immediately so referral is not delayed.

CLASSIFY

USE ALL BOXES THAT MATCH THE CHILD'S SYMPTOMS AND PROBLEMS TO CLASSIFY THE ILLNESS.

IDENTIFY TREATMENT

THEN ASK ABOUT MAIN SYMPTOMS:

Does the child have cough or difficult breathing?

IF YES, ASK:

- For how long?

LOOK, LISTEN, FEEL:

- Count the breaths in one minute.
- Look for chest indrawing.
- Look and listen for stridor.

CHILD MUST BE CALM

Classify COUGH or DIFFICULT BREATHING

If the child is:	**Fast breathing is:**
2 months up to 12 months	50 breaths per minute or more
12 months up to 5 years	40 breaths per minute or more

SIGNS	**CLASSIFY AS**	**TREATMENT** (Urgent pre-referral treatments are in bold print.)
• Any general danger sign or • Chest indrawing or • Stridor in calm child	**SEVERE PNEUMONIA OR VERY SEVERE DISEASE**	• ***Give first dose of an appropriate antibiotic.*** • ***Refer URGENTLY to hospital.****
• Fast breathing.	**PNEUMONIA**	• ***Give an appropriate antibiotic for 5 days.*** • Soothe the throat and relieve the cough with a safe rememdy. • Advise mother when to return immediately. • Follow-up in 2 days.
No signs of pneumonia or very severe disease.	**NO PNEUMONIA: COUGH OR COLD**	• If coughing more than 30 days, refer for assessment. • Soothe the throat and relieve the cough with a safe remedy. • Advise mother when to return immediately. • Follow-up in 5 days if not improving.

* If referral is not possible, manage the child as described in *Management of Childhood Illness, Treat the Child, Annex: Where Referral Is Not Possible*, and *WHO* guidelines for inpatient care.

Reprinted with permission from World Health Organization, ***Integrated Management of Childhood Illnesses Chart***, 1995, pp 2–6.

BEST COPY AVAILABLE

TRAINEE HANDOUT
PAGE 2 OF 5

ASSESS AND CLASSIFY THE SICK CHILD – AGE 2 MONTHS UP TO 5 YEARS

Does the child have diarrhoea?:

IF YES, ASK:

- For how long?
- Is there blood in the stool?

LOOK, LISTEN, FEEL:

- Look at the child's general condition. Is the child:
  - – Lethargic or unconscious?
  - – Restless and irritable?
- Look for sunken eyes.
- Offer the child fluid. Is the child:
  - – Not able to drink or drinking poorly?
  - – Drinking eagerly, thirsty?
- Pinch the skin of the abdomen. Does it go back:
  - – Very slowly (longer than 2 seconds)?
  - – Slowly?

Classify DIARRHOEA

for DEHYDRATION

SIGNS	CLASSIFY AS	TREATMENT (Urgent pre-referral treatments are in bold print.)
Two of the following signs: • Lethargic or unconscious • Sunken eyes • Not able to drink or drinking poorly • Skin pinch goes back very slowly	**SEVERE DEHYDRATION**	• If child has no other severe classification: – Give fluid for severe dehydration (Plan C). OR ***If child also has another severe classification:*** ***– Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way Advise the mother to continue breast-feeding*** • ***If child is 2 years or older and there is cholera in your area, give antibiotic for cholera***
Two of the following signs: • Restless, irritable • Sunken eyes • Drinks eagerly, thirsty • Skin pinch goes back slowly	**SOME DEHYDRATION**	• Give fluid and food for some dehydration (Plan B). ***If child also has another severe classification:*** ***– Refer URGENTLY to hospital with mother giving frequent sips of ORS on the way Advise the mother to continue breast-feeding*** • Advise mother when to return immediatley • Follow-up in 5 days if not improving.
Not enough signs to classify as some or severe dehydration.	**NO DEHYDRATION**	• Give fluid and food to treat diarrhoea at home (Plan A). • Advise mother when to return immediately • Follow-up in 5 days if not improving.

and if diarrhoea 14 days or more

SIGNS	CLASSIFY AS	TREATMENT
• Dehydration present.	**SEVERE PERSISTENT DEHYDRATION**	• Treat dehydration before referral unless the child has another severe classification. • Refer to hospital
• No dehydration.	**PERSISTENT DEHYDRATION**	• Advise the mother on feeding a child who has PERSISTENT DIARRHOEA. • Follow-up in 5 days.

and if blood in stool

SIGNS	CLASSIFY AS	TREATMENT
• Blood in the stool.	**DYSENTERY**	• ***Treat for 5 days with an oral antibiotic recommended for Shigella in your area.*** • Follow-up in 2 days.

91

92

BEST COPY AVAILABLE

ASSESS AND CLASSIFY THE SICK CHILD – AGE 2 MONTHS UP TO 5 YEARS

Does the child have diarrhoea?:

IF YES:

Decide Malaria risk: high or low

THEN ASK:

- For how long?
- If more than 7 days, has fever been present every day?
- Has the child had measles within the last 3 months?

LOOK, LISTEN, FEEL:

- Look or feel for stiff neck.
- Look for runny nose.

Look for signs of MEASLES

- Generalized rash and
- One of these: cough, runny nose, or red eyes.

If the child has measles now or within the last 3 months?

- Look for mouth ulcers. Are they deep and extensive?
- Look for pus draining from the eye.
- Look for clouding of the cornea.

Classify FEVER

	SIGNS	CLASSIFY AS	TREATMENT (Urgent pre-referral treatments are in bold print.)
High Malaria Risk	• Any general danger sign or • Stiff neck	**VERY SEVERE FEBRILE DISEASE**	• ***Give quinine for severe malaria (first does).*** • ***Give first does of an appropriate antibiotic.*** • ***Treat the child to prevent low blood sugar.*** • ***Give one dose of paracetamol in clinic for high fever (38.5˚ C or above).*** • ***Refer URGENTLY to hospital.***
	• Fever (by history or feels hot or temperature 37.5˚ C** or above).	**MALARIA**	• ***If NO cough with fast breathing, treat with oral antimalarial*** ***OR*** ***If cough with fast breathing, treat with cotrimoxazole for 5 days.*** • ***Give one dose of paracetamol in clinic for high fever (38.5˚ C or above).*** • *Advise mother when to return immediatley* • *Follow-up in 2 days if fever persists.* • *If fever is present every day for more than 7 days, refer for assessment.*
Low Malaria Risk	• Any general danger sign or • Stiff neck	**VERY SEVERE FEBRILE DISEASE**	• ***Give quinine for severe malaria (first dose) unless no malaria risk.*** • ***Give first does of an appropriate antibiotic.*** • ***Treat the child to prevent low blood sugar.*** • ***Give one does of paracetamol in clinic for high fever (38.5˚ C or above).*** • ***Refer URGENTLY to hospital.***
	• NO runny nose and NO measles and NO other cause of fever	**MALARIA**	• ***If NO cough with fast breathing, treat with oral antimalarial*** ***OR*** ***If cough with fast breathing, treat with cotrimoxazole for 5 days.*** • ***Give one dose of paracetamol in clinic for high fever (38.5˚ C or above).*** • Advise mother when to return immediatley • Follow-up in 2 days if fever persists. • If fever is presnet every day for more than 7 days, refer for assessment.
	• Runny nose PRESENT or • Measles PRESENT or Other cause of fever PRESENT	**FEVER – MALARIA UNLIKELY**	• ***Give one dose of paracetamol in clinic for high fever (38.5˚ C or above).*** • Advise mother when to return immediatley • Follow-up in 2 days if fever persists. • If fever is present every day for more than 7 days, refer for assessment.
If MEASLES now or within last 3 months, Classify	• Any general danger sign or • Clouding of cornea or • Deep or extensive mouth ulcers	**SEVERE COMPLICATED MEASLES*****	• ***Give Vitamin A.*** • ***Give first does of an appropriate antibiotic.*** • ***If clouding of the cornea or pus draining from the eye, apply tetracycline eye ointment.*** • ***Refer URGENTLY to hospital.***
	• Pus draining from the eye or • Mouth ulcers	**MEASLES WITH EYE OR MOUTH COMPLICATIONS*****	• ***Give Vitamin A.*** • ***If pus draining from the eye, treat eye infection with tetracycline eye ointment.*** • If mouth ulcers, treat with gentian violet • Follow-up in 2 days.
	• Measles now or within the last 3 months	**MEASLES**	• ***Give Vitamin A.***

** These temperatures are based on auxiliary temperature. Rectal temperature readings are approximately 0.5˚ C higher.

*** Other important complications of measles – pneumonia, stridor, diarrhoea, ear infection, and malnutrition – are classified in other tables.

BEST COPY AVAILABLE

TRAINEE HANDOUT
PAGE 4 OF 5

ASSESS AND CLASSIFY THE SICK CHILD – AGE 2 MONTHS UP TO 5 YEARS

Does the child have an ear problem?

IF YES, ASK:

- Is there ear pain?
- Is there ear discharge? If yes, for how long?

LOOK, LISTEN, FEEL:

- Look for pus draining from the ear.
- Feel for tender swelling behind the ear.

Classify EAR PROBLEM

SIGNS	CLASSIFY AS	TREATMENT (Urgent pre-referral treatments are in bold print.)
• Tender swelling behind the ear	**MASTOIDITIS**	• ***Give first dose of an appropriate antibiotic.*** • ***Give first dose of paracetamol for pain.*** • ***Refer URGENTLY to hospital.***
• Pus is seen draining from the ear and discharge is reported for less than 14 days, or • Ear pain.	**ACUTE EAR INFECTION**	• ***Give an antibiotic for 5 days.*** • Give paracetamol for pain. • Dry the ear by wicking. • Follow-up in 2 days if fever persists.
• No ear pain and • No pus seen draining from the ear.	**NO EAR INFECTION**	No additional treatment.

ASSESS AND CLASSIFY THE SICK CHILD – AGE 2 MONTHS UP TO 5 YEARS

Then check for malnutrition and anaemia

LOOK, LISTEN, FEEL:

- Look for visible severe wasting.
- Look for palmar pallor. Is it:
  - Severe palmar pallor?
  - Some palmar pallor?
- Look for oedema of both feet.
- Determine weight for age.

Classify NUTRITIONAL STATUS

SIGNS	CLASSIFY AS	TREATMENT (Urgent pre-referral treatments are in bold print.)
• Visible severe wasting or • Severe palmar pallor or • Oedema of both feet	**SEVERE MALNUTRITION OR SEVERE ANAEMIA**	• ***Give Vitamin A.*** • ***Refer URGENTLY to hospital.***
• Some palmar pallor or • Very low weight for age.	**ANAEMIA OR VERY LOW WEIGHT**	• Assess the child's feeding and counsel the mother on feeding according to the FOOD box on the *COUNSEL THE MOTHER* chart. – If feeding problem, follow-up in 5 days. • If pallor: – Give iron. – Give oral antimalarial if high malaria risk. – Give mebendazole if child is 2 years or older and has not had a dose in the previous 6 months. • Advise mother when to return immediately. • If pallor, follow-up in 14 days. If very low weight for age, follow-up in 30 days.
• Not very low weight for age and no other signs of malnutrition.	**NO ANAEMIA AND NOT VERY LOW WEIGHT**	• If child is less than 2 years old, assess the child's feeding and counsel the mother on feeding according to the FOOD box on the *COUNSEL THE MOTHER* chart. – If feeding problem, follow-up in 5 days. • Advise mother when to return immediately.

Then check the child's immunization status

IMMUNIZATION SCHEDULE:	AGE	VACCINE	
	Birth	BCG	OPV-0
	6 weeks	DPT-1	OPV-1
	10 weeks	DPT-2	OPV-2
	14 weeks	DPT-3	OPV-3
	9 months	Measles	

Assess other problems

MAKE SURE CHILD WITH ANY GENERAL DANGER SIGN IS REFERRED after first dose of an appropriate antibiotic and other urgent treatments.
Exception: Rehydration of the child according to Plan C may resolve danger signs so that referral is no longer needed.

SESSION PLAN

PART TWO–SESSION 5:
CHECKING THE CHILD'S IMMUNIZATION STATUS

OVERVIEW

Immunizations are one of the best ways of preventing childhood illnesses. In this session the Trainees learn about immunizations, the WHO recommended schedule for giving immunizations, how and when to check a child's immunization status, and the contraindications to giving immunizations.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain basic information about child health immunizations.
2. Describe the status of immunization programs in their host country.
3. Practice applying immunization knowledge in "real" situations.

TIME

30 minutes

MATERIALS

A copy of the WHO training module, ***Assess and Classify Sick Child Age Two Months Up to Five Years***, for each Trainee. If possible, obtain a copy of the type of immunization records used in-country.

PREPARATION

Prior to this session ask the Trainees to read section 8.0, Check the Child's Immunization Status, in the booklet ***Assess and Classify the Sick Child Age Two Months Up to Five Years***. Tell them they will be tested on this material and should bring the booklet with them to this session. They should also review the chapter on immunizations in their ***Facts For Life*** booklet.

Familiarize yourself with the type of immunizations given in the host country and their schedules. Find out how a local health care worker obtains an immunization history if the mother does not have a record.

MATERIALS

Handout: *Checking the Child's Immunization Status*

DELIVERY

STEP 1. Ask the Trainees to describe the importance of immunization, based on their homework.

STEP 2. Ask them to name and describe the four immunizations that all children should receive.

Answers: BCG, OPV, DPT, and measles

- BCG is an immunization against tuberculosis. The initials stand for Bacille Calmette-Guerin.
- OPV is oral polio vaccine and is given to prevent polio.
- DPT is an immunization to prevent diphtheria, pertussis (whooping cough), and tetanus.

STEP 3. Distribute the handout *Checking the Child's Immunization Status* and ask the Trainees to answer Parts One and Two. Give them ten minutes to complete this exercise.

STEP 4. Go over their answers and discuss any questions they may have. If there are different immunizations or different schedules of immunizations in the host country, discuss these differences with the Trainees. Discuss how immunizations are recorded and the type of immunization records used in the country. Show them an example of the type of records used (if you have obtained such a record) and discuss how to obtain an immunization history if the mother does not have a record.

Answers to Part One:

If the child:	Immunize this child today if due for immunization	Do not immunize today
will be treated at home with antibiotics	++	
has a local skin infection	++	
had a convulsion immediately after DPT 1 and needs DPT 2 and OPV today		++
has a chronic heart problem	++	
is being referred for vomiting		++
is exclusively breast-fed	++	
older brother had a convulsion last year	++	
is very low weight for age	++	
is known to have AIDS and has not received any immunizations at all		++
has no pneumonia, cough or cold	++	

Answers to Part Two:

1. a. No; **1. b.** Needs DPT 3 and OPV 3; **1. c.** At 9 months old.

2. a. No; **2. b.** Needs DPT 2 and OPV 2; **2. c.** DPT 3 and OPV 2 (repeated); **3.d.** In four weeks.

3. a. No; **2. b.** Needs DPT 3, OPV 3 and measles; **3. c.** Has finished his immunizations.

101

TRAINEE HANDOUT
PAGE 1 OF 2

CHECKING THE CHILD'S IMMUNIZATION STATUS

PART ONE:

Decide if a contraindication is present for each of the following children and check the appropriate box:

If the child:	**Immunize this child today if due for immunization**	**Do not immunize today**
will be treated at home with antibiotics		
has a local skin infection		
had a convulsion immediately after DPT 1 and needs DPT 2 and OPV today		
has a chronic heart problem		
is being referred for vomiting		
is exclusively breast-fed		
older brother had a convulsion last year		
is very low weight for age		
is known to have AIDS and has not received any immunizations at all		
has no pneumonia, cough or cold		

Reprinted with permission from ***Assess and Classify the Sick Child Age Two Months Up to Five Years***, World Health Organization, 1995.

TRAINEE HANDOUT
PAGE 2 OF 2

CHECKING THE CHILD'S IMMUNIZATION STATUS

PART TWO:

Read about the following children and answer the questions.

1. **Salim, 6 months old.** Has no danger signs. Assessed as no pneumonia, cough or cold, and no anemia. He is not very low weight for age.

   Immunization history: BCG, OPV 0, OPV 1, OPV 2, DPT 1 and 2.
   OPV 2 and DPT 2 given 6 weeks ago.

   a. Is Salim up-to-date with his immunizations?

   b. What immunizations, if any, does Salim need today?

   c. When should he return for his next immunization?

2. **Chilunji, age 3 months old.** Has no danger signs. Assessed as having diarrhea with no dehydration and also having anemia.

   Immunization history: BCG, OPV 0, OPV 1, and DPT 1.
   OPV 1 and DPT 1 given 5 weeks ago.

   a. Is Chilunji up-to-date with her immunizations?

   b. What immunizations, if any, does Chilunji need today?

   c. Chilunji has diarrhea. What immunizations will she receive at her next visit?

   d. When should she return for her next immunizations?

3. **Marco, age 9 months old.** Has no danger signs. Assessed as having pneumonia, malaria, no anemia, and not very low weight for age.

   Immunization history: BCG, OPV 0, OPV 1 and DPT 1.
   When Marco was 7 months old, he received OPV 2 and DPT 2.

   a. Is Marco up-to-date on his immunizations?

   b. What immunizations, if any, does Marco need today?

   c. When should he return for his immunizations?

Reprinted with permission from ***Assess and Classify the Sick Child Age Two Months Up to Five Years***, World Health Organization, 1995.

SESSION PLAN

PART TWO–SESSION 6:
DETERMINING WEIGHT FOR AGE

OVERVIEW

The WHO has developed a weight for age chart which is used in developing countries to determine a child's nutritional status. Weight for age compares the child's weight with the weight of other children who are the same age.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe the weight for age concept.
2. Apply the weight for age technique.

TIME

15 minutes

MATERIAL

Handouts:

- *WHO Prototype Growth Chart*
- *Determining Weight for Age*

DELIVERY

STEP 1. Tell the Trainees that they may be encountering malnourished children in their work and the weight for age chart is a tool they can use to determine a child's nutritional status.

STEP 2. Distribute the handout and three copies of the WHO growth chart to each Trainee. Ask the Trainees to read through the instructions on how to determine weight for age. Then ask them to read the three examples and determine the weight for age for each example on the charts provided.

STEP 3. Ask the Trainees to turn to their neighbor and discuss the three situations. See if they agree on the answers. Briefly review the answers with the whole group.

Answers: Dan is normal for age; Teresa is very low weight for age; and Antonio is low weight for age.

STEP 4. Explain to the Trainees that if a child is very low weight for age, they need to assess the child's feeding patterns and problems and know how to counsel the mother about appropriate feeding practices. The exercises in the session **Counseling the Mother about Breast-feeding and Complementary Foods**, p. 94, will give them the knowledge and skills to do this.

TRAINEE HANDOUT
PAGE 1 OF 2

DETERMINING WEIGHT FOR AGE

Weight for age compares the child's weight with the weight of other children who are the same age. Look at the WHO weight for age chart on the next page. To determine weight for age:

1. Calculate the child's age in months.

2. Weigh the child if they have not been weighed that day. Use a scale which you know gives accurate weights. The child should wear light clothing when they are weighed. Ask the mother to help remove clothing such as a coat, sweater, or shoes.

3. Use the weight for age chart to determine the child's weight for age.
   a. Look at the left-hand axis to locate the line that shows the child's weight.
   b. Look at the bottom axis of the chart to locate the line that shows the child's age in months.
   c. Find the point on the chart where the line for the child's weight meets the line for the child's age. Mark this point with a large dot.

4. Note if the point is above, on, or below the bottom curve.
   a. If the point is below the bottom curve, the child is ***very low*** weight for age. You need to pay special attention to how these children are fed.
   b. If the point is above or on the bottom curve, this child is ***not*** very low weight for age. These children can still be malnourished, but their condition is not as serious as those whose weight is below the bottom line.

Read the following examples and determine the child's weight for age on the WHO charts provided. Use a different chart for each example.

Example 1: Dan is 9 months old and weighs 9.5 kg.

Dan's weight for age is ____________________

Example 2: Teresa is 6 months old and weighs 4 kg.

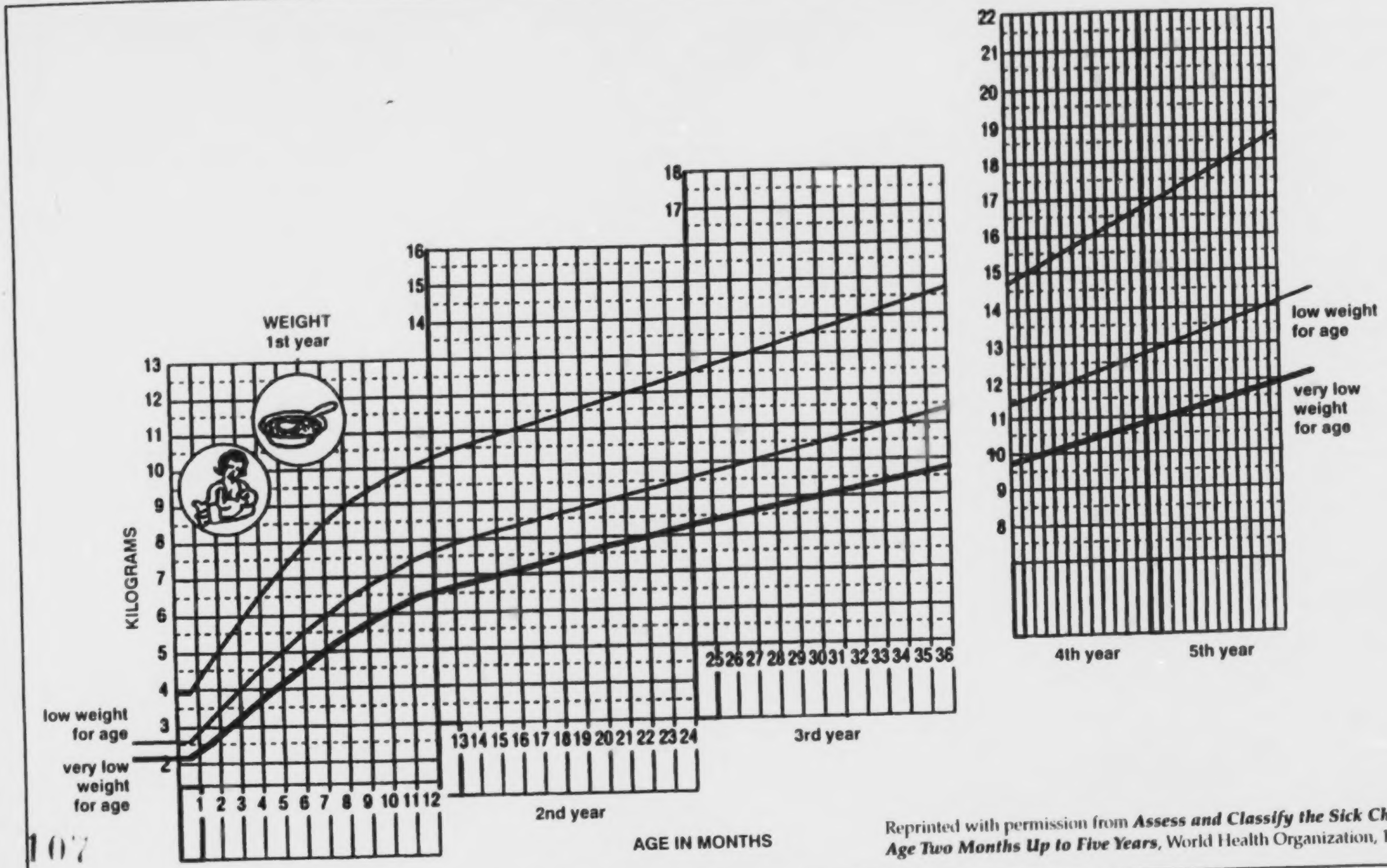
Teresa's weight for age is ____________________

Example 3: Antonio is 37 months old and weighs 11.5 kg.

Antonio's weight for age is ____________________

TRAINEE HANDOUT
PAGE 2 OF 2

WHO PROTOTYPE GROWTH CHART



Reprinted with permission from ***Assess and Classify the Sick Child Age Two Months Up to Five Years***, World Health Organization, 1995.

BEST COPY AVAILABLE

SESSION PLAN

PART TWO–SESSION 7:

COUNSELING THE MOTHER ABOUT BREAST-FEEDING AND COMPLEMENTARY FOODS

OVERVIEW

In the previous session the Trainees learned how to assess a child's nutritional status. In this session they will learn how to assess feeding practices and how to counsel the mother about feeding her child. The World Health Organization has developed a training module for this purpose which is called ***Counsel the Mother*** and is part of the Management of Childhood Illnesses series which was introduced in the session **Assessing the Sick Child: Case Studies**, p. 65, of this manual.

You should note that there is a lot of material to cover in this session. Before presenting the session read through the exercises and decide if you need to cover all the material. You may want to divide it into two sessions.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe main factors in child nutrition, especially breast-feeding and complementary foods.
2. Identify local practices concerning nutrition and the feeding of children.
3. Apply nutrition information in the form of advising mothers about their children.

TIME

60–90 minutes

MATERIALS

Booklets:

- ***Counsel the Mother***
- ***Integrated Management of Childhood Illnesses (IMCI) Chart*** (unless distributed previously).

PREPARATION

Prior to this session distribute the ***Counsel the Mother*** booklet and ask the Trainees to read pages 3–10. Ask them to then gather the following information from their host families, language instructors, and/or community members:

a) What are the feeding practices in the community for children in each of the following age groups:

- Newborn up to 4 months?
- 4 months up to 6 months?
- 6 months up to 12 months?
- 2 months up to 2 years?
- 2 years and older?

b) What complementary foods are available in the community for children 4–6 months and 6–12 months?

c) What appropriate foods are available locally for children 12 months to two years and two years and older?

Remind the Trainees to bring the ***Counsel the Mother*** booklet with them to the session

DELIVERY

STEP 1. Introduce the session and ask the Trainees to open their ***Counsel the Mother*** booklets to page 11. Have them answer the questions in Exercise A.

STEP 2. Solicit the answers from the Trainees and discuss any questions they may have. Discuss the feeding recommendations on pages 3–10 and ask them for the information they gathered from the community in questions a–c above. Have the Trainees fill in the blanks on pages 6, 8, and 9 of the booklet.

STEP 3. Divide the Trainees into pairs. Ask each pair to read through section 1.0, "Assess the Child's Feeding" (p. 13) and do the short answer exercise on p. 14. They may check their own answers by comparing them to the answers given at the end of the module (p. 61).

STEP 4. Ask each pair to read through section 2.0, "Identify Feeding Problems" (p. 15), and insert examples of feeding problems they may have observed in their host family or in the community. Ask them to continue reading the section and add any other problems they may have observed in their host family homes or the community.

STEP 5. Ask one pair to do the role play on page 18 (Exercise B). Give them a few minutes to prepare. Ask the remaining Trainees to observe the role play and record the mother's answers on the form at the bottom of page 18. They should also record feeding problems and correct feeding practices.

STEP 6. Ask the pairs to continue reading section 3.0 and 3.1, "Give Relevant Advice," (pp. 19–24) and have them complete the questions on pages 25–30 (Exercise C). Discuss their answers as a group.

STEP 7. Distribute the ***IMCI Chart*** Booklet and ask the Trainees to turn to page 19 to review "Counseling the Mother about Feeding Problems." Then have them turn to page 28 of the IMCI Chart and review the guidelines on correct positioning and attachment for breast-feeding.

STEP 8. Return to the ***Counsel the Mother*** Booklet and review the communication skills on page 31, Section 3.2, "Use Good Communication Skills," and ask the pairs to complete the short answer exercise on page 32–33. Have them check their own answers on pages 61–62.

STEP 9. Ask two Trainee-pairs to do Role Plays 1 and 2. Give them a few minutes to prepare. Ask the remaining Trainees to be observers and record information on the forms given on pages 37 and 39. After each role play, discuss the questions on pages 38–39 and page 40.

STEP 10. Go over the information on page 41, section 4.0, "Advise the Mother to Increase Fluid During Illness" with the whole group. Then ask them to read sections 5.0 and 6.0 on their own.

111

SESSION PLAN

PART TWO–SESSION 8:

WATER AND SANITATION DISEASES AND THEIR PREVENTION

OVERVIEW

Water and sanitation-related diseases include various types of diarrhea, worm infestations, skin and eye diseases, and mosquito-borne diseases. Together they form some of the most frequent causes of illness and death in the developing world. In this session the Trainees learn about the prevention of these diseases and what questions or observations they should make when gathering information in the community. This information can be used by Trainees in designing a hygiene education and prevention program at their sites.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe the cause and prevention of childhood diseases associated with water and sanitation problems.
2. Match various diseases with their probable causes.
3. Assess their own community and home with regard to these diseases and conditions.

TIME

30–45 minutes

MATERIALS

Control of Communicable Diseases Manual

Handout: *Prevention of Water and Sanitation-related Diseases*

STAFF

HCN staff or resource person who can discuss common water and sanitation beliefs and practices in different economic level communities. This resource person could be a Public Health Inspector or a current Volunteer working in water and sanitation.

DELIVERY

STEP 1. Introduce the HCN/resource person and explain the purpose of this session. Explain to the Trainees that water and sanitation projects aim at preventing diarrhea, worm infestations, skin and eye diseases, and mosquito-borne diseases. These projects contribute to:

- improving public health and personal well-being.
- reducing costs of curative health services.
- higher productivity of school children and working people because less energy is lost from poor health and illness.

STEP 2. Distribute the handout. Using ***Communicable Diseases in Man*** as a reference, give a brief description of each of the diseases listed in Part One of the handout and discuss how they are transmitted. As you discuss each disease, ask the Trainees to place a check mark under those measures that apply to preventing that disease. Discuss any questions they may have.

Answers to Part One:

Disease	**Safe drinking water**	**Safe excreta disposal**	**Personal and domestic hygiene**	**Food hygiene**	**Wastewater disposal/ drainage**
Diarrheas	X	X	X	X	
Polio and Hepatitis A	X	X	X	X	
Worm infections:					
ascaris, trichuris	X	X	X	X	X
hookworm		X	X		
pinworm		X	X	X	
tapeworms		X	X	X	
schistosomiasis		X	X		X
guinea worm	X				
Skin infections			X		
Eye infections		X	X		
Insect transmitted diseases:					
malaria					X
yellow fever			X		X
dengue			X		X
filiriasis		X			X

Discussion points:

Personal hygiene refers to water (and soap or substitute) used for cleaning the body, including bathing and washing the eyes, face, and hands. Domestic hygiene refers to the use of water in keeping the home clean, as well as cleansing those components of the home environment that are related to disease transmission (e.g., clothes, utensils, floors, counter tops, or towels). The category "personal and domestic hygiene" also includes safe collection, transportation, storage, and use of drinking water. In the case of schistosomiasis, personal and domestic hygiene relates to reduced contact with infected water and increased use of improved water supplies for bathing and washing.

STEP 3. Summarize by saying that there are many transmission routes of water and sanitation-related diseases. Ask Trainees to suggest them and list them on a flip chart:

- Water source
- Water collection
- Water storage
- Drinking water
- Water use
- Food handling
- Excreta disposal
- Wastewater disposal

STEP 4. Ask the Trainees to turn to Part 2 of the handout *Prevention of Water and Sanitation-related Diseases.* Then ask them to think about the home or community where they are staying and answer the questions given based on their observations. Give them 10-15 minutes to answer these questions.

STEP 5. Have the HCN staff or resource person go over the questions and solicit answers from the Trainees. Then ask the HCN resource person to discuss common beliefs and practices in the host country, especially if they differ between the Trainees' host families and lower economic level families in-country.

STEP 6. If the Trainees did not have enough information about the practices in their host families to answer all of the questions in Part 2, ask them to make further observations in their homes to gather this information.

RESOURCE

Just Stir Gently (ICE # WS113)

ADDITIONAL RESOURCE

In-country Volunteer health handbook which can be obtained from the PCMO.

TRAINEE HANDOUT
PAGE 1 OF 3

PREVENTION OF WATER AND SANITATION-RELATED DISEASES

PART ONE:

The following table represents a list of water and sanitation-related diseases (in the left-hand column) and five basic measures which help prevent these diseases. The trainer will present a brief description of each of the diseases and how they are transmitted. As you listen to the presentation, place a check mark under those measures that apply to preventing each disease.

Disease	Safe drinking water	Safe excreta disposal	Personal and domestic hygiene	Food hygiene	Wastewater disposal/ drainage
Diarrhea					
Polio and Hepatitis A					
Worm infections: ascaris, trichuris hookworm pinworm tapeworms schistosomiasis guinea worm					
Skin infections					
Eye infections					
Insect transmitted diseases: malaria yellow fever dengue filiriasis					

TRAINEE HANDOUT
PAGE 2 OF 3

PREVENTION OF WATER AND SANITATION-RELATED DISEASES

PART TWO:

As there are many transmission routes of water and sanitation-related diseases, hygiene education and prevention may cover a wide range of action points. The following is a list of questions for identifying these action points. Think about the home or community where you are staying and answer these questions to the best of your ability.

ACTION POINTS	YES	NO
Water Source:		
• Do all children, women and men in your home or community use safe water sources for drinking, clothes washing, and bathing?		
• Is water used efficiently (not wasted) and is wastewater properly drained?		
• Are improved water sources used with care and well maintained?		
• Is there a risk of contamination of water sources from nearby		
• Are there latrines, wastewater disposal, free ranging cattle, or land cultivation?		
Water Collection:		
• Is drinking water collected in clean vessels without coming into contact with hands?		
• Is water transported in a covered container?		
Water Storage:		
• Is water stored in vessels which are covered and regularly cleaned?		
• Is drinking water stored in a separate container, if possible?		
Drinking Water:		
• Is drinking water taken from the storage vessel in such a way that hands, cups, or other objects cannot contaminate the water?		

TRAINEE HANDOUT
PAGE 3 OF 3

PREVENTION OF WATER AND SANITATION-RELATED DISEASES

ACTION POINTS (continued)	**YES**	**NO**
Water Use:		
• Are adequate amounts of water available, transported and used for personal and domestic hygiene? (It is estimated that some 30 to 40 liters per person per day are needed for personal and domestic hygiene.)		
Food Handling:		
• Are hands washed with soap or ash before preparing and eating food?		
• Are vegetables and fruit washed with safe water and is food properly covered?		
• Are kitchen utensils washed with safe water and left in a clean place?		
Excreta Disposal:		
• Do all men, women, and children use hygienic means of excreta disposal at home, at work, and at school?		
• Are stools of infants and young children safely disposed of?		
• Are household latrines used by all family members throughout the year and are these regularly cleaned and maintained?		
• Are latrines sited in such a way that the pit contents cannot into water sources or enter the groundwater table?		
• Are hand washing facilities and soap or ash available and are hands always washed after defecation, and after helping babies and little children?		
Wastewater Disposal:		
• Is household wastewater disposed of or re-used properly? Are measures taken to ensure that wastewater is not left to create breeding places for mosquitoes and other disease transmission vectors, or to contaminate the safe water?		

PART THREE: ENTERING THE COMMUNITY

INTRODUCTION

In addition to being familiar with the basics of child health, Volunteers need the skills necessary to become accepted by their community. This is a crucial step in being able to work with counterparts and other members of the community in carrying out health activities and projects. The exercises in this section are meant to complement the information presented in **Part Two: Fundamentals of Child Health** to prepare Trainees to become effective child health Volunteers.

SUMMARY OF SESSIONS

SESSION 1: **Why is it Important to Work with the Community?** establishes why community involvement in and support of a Volunteer's health activities is so important, and identifies why Volunteers sometimes fail to get such involvement.

SESSION 2: **Getting Involved in Your Community** helps Volunteers discover how they can become more integrated into the life of their community.

SESSION 3: **Establishing Credibility in Your Community** discusses how important it is that Volunteers show that they know what they are doing and understand how the community functions prior to starting to work.

SESSION 4: **Working with Counterparts and the Community** explores different styles of working with host country nationals and discusses the advantages and disadvantages of each.

SESSION 5: **Cross-Cultural Critical Incidents** examine some of the typical cross-cultural differences and difficulties that Volunteers encounter.

WHEN SHOULD THESE SESSIONS BE DONE?

It is important that Trainees always have counterparts and the community in mind as they go through the various parts of technical training. As they complete the various tasks and activities in this manual, many of which will be repeated when they become Volunteers, they should be thinking about how they would involve and work with the community.

Therefore, present these sessions as early as possible during PST, to establish from the beginning the theme that Volunteers won't be doing things on their own, but involving themselves in various community activities and getting community support for their initiatives.

If possible, present this section simultaneously with the next section, "Understanding the Setting," which contains more "hands-on" activities in the community. This will combine theoretical exercises with practical activities and provide an excellent foundation for meaningful discussions about why it is important to be involved in the community and how it can be done. If this is not feasible, then this part should be done prior to Part Four.

SESSION PLAN

PART THREE–SESSION 1:
WHY IS IT IMPORTANT TO WORK WITH THE COMMUNITY

OVERVIEW

Community involvement in and support for Volunteer work is essential to success, but this fact may not be apparent to many Trainees. Either they don't understand why such involvement is important, or they assume that it is automatic and inevitable and that they don't need to talk about it, much less plan for it—"We *live* in communities, after all, so how can they not be involved in what we do?"—In the first instance, Trainees need to see why involving the community is important, and in the second, they need to see that getting the community involved is neither inevitable nor especially easy. This session demonstrates why community involvement is important and why it can be difficult.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe why it is important for Volunteers to work with members of the community.
2. Discuss why many Volunteers end up not working with the community.

TIME

30 minutes

MATERIALS

Flip chart paper, markers

Handout: *Why Is It Important to Work with the Community?*

DELIVERY

STEP 1. Introduce the exercise by saying that technical competence alone is not enough to be an effective Volunteer. Volunteers have to get the involvement and support of the community in what they do.

STEP 2. Distribute the handout and say that in this exercise they are going to be looking at 1) why community involvement is so important and 2) why Volunteers often fail to involve the community in their child health activities.

STEP 3. Form three groups and assign one case study to each group. Ask them to discuss why these Volunteer projects failed, and what the Volunteers could have done to prevent the outcomes. Ask someone in each group to record the answers to the question.

STEP 4. Reconvene the whole group. Ask each group to present their case, including answers to the question "What could the Volunteer have done to prevent this outcome?" Make sure that their answers include the following key points for each case study:

1. In any development project it is important to first analyze what skills and/or knowledge the community members need to continue a project after Volunteers have finished their service. This means developing or transferring these skills and knowledge to the community. Jennifer failed to recognize this. She should have trained one, several, or all of the women how to fill out the forms, maintain records, and fulfill the requirements of the bank. The fact that the women were illiterate means she would have had to teach them basic reading, writing and arithmetic skills or found someone in the community who could do this for her.

2. Any community development project needs to begin with understanding the setting and finding out what the needs of the community are from *its* perspective. Community development workers need to make sure they are assisting the community to identify and meet their own needs, not those of the Volunteers. It has to be *the community's* project, not *yours*. This is a common reason projects fail. Barbara, because of her previous experience and connections, did what *she* wanted to do without taking the time to find out if this was what the people wanted or needed.

3. The community has knowledge and information that could be critical to the success of a project. Before beginning a project, it is important to find out from the community not only what they need and want,

but who are the leaders, who is credible and motivated, who will have the most influence in helping to make the project a success, what are the local resources and assets that could be used in the project, and so on. Steve did not take the time to do this and made the mistake of relying on someone who was not credible in the community, so no one else came to help.

STEP 5. Ask the Trainees to identify common reasons why Volunteers do not involve the community or do not get community support for their activities. Write their answers on a flip chart. These should include, but not be limited to, the following:

1. The language barrier makes it hard to work with HCNs.
2. Cultural differences make it hard to work with HCNs.
3. The Volunteer is not very well integrated into the community (perhaps because of 1 and 2) and doesn't have people they can approach to work with.
4. It is quicker and easier working on your own.
5. The Volunteer feels pressure from Peace Corps to get results, to get activities and projects off the ground, and it is quicker to do something yourself.
6. The Volunteer prefers to do his/her own activity, not the activity the community wants to do, because:
   - **a.** The Volunteer wants the credit/glory for starting something new.
   - **b.** The Volunteer thinks what the community wants to do is not very important.
   - **c.** The Volunteer wants to do the activity his/her way and the community wants to do it a different way; therefore she/he doesn't get much community support.
   - **d.** The Volunteer wants to feel she/he has accomplished something, and the project she/he has been assigned to seems to be going nowhere.

STEP 6. Lead a discussion in which Trainees explain how they think they can prevent these things from happening. Pose one or two hypothetical cases, using the reasons above, and ask what a Trainee could do to keep from falling victim to some of these attitudes.

STEP 7. Close by saying that now that the Trainees have seen how important it is to involve the community, as well as why it might be difficult. In the following sessions they will be looking at ways to make it easier to get involvement and support.

TRAINEE HANDOUT

WHY IS IT IMPORTANT TO WORK WITH THE COMMUNITY?

Working with members of the community is an important principle of all development work. Many well-intentioned and much-needed development projects have failed because the health experts designing and executing them did not consult the intended beneficiaries. Read the following case studies to identify the key reasons why working with the community is so important.

CASE STUDY #1:

Jennifer, a Volunteer who had a background in accounting, developed an income-generation project for women in her village. The women were poor and illiterate, but very motivated. They had many ideas for different things they could do to generate income for their families, but needed to borrow money from the bank to get started. Jennifer set up a system with the bank to get the loans. This required filling out many forms and maintaining a record system with receipts to be given to the bank every month. Jennifer took on this responsibility because she felt this was the best way she could participate in the project. When she went home, the project fell apart. What could the Volunteer have done to prevent this outcome?

CASE STUDY #2:

Barbara was a Volunteer who had several years of experience working with family planning in the United States prior to her Peace Corps assignment. When she arrived at her post, she decided to do a family planning project. Because of her previous connections, she was able to get quite a large grant which impressed the local leaders. With this money, she trained the local health workers, set up a clinic, and bought the necessary supplies. Initially a few people came and the health workers gave out condoms and family planning pills, but after awhile no one showed up. A friend finally told Barbara that the people are not interested in family planning because having sons is important to them. Because of the high infant mortality rate, they can not afford to practice family planning. What they really need are vaccinations to prevent common childhood illnesses and nutritious food to prevent malnutrition. What could the Volunteer have done to prevent this outcome?

CASE STUDY #3:

Steve was a Volunteer assigned to a reforestation project. When he first started his work, he made good friends with a man in the village who spoke English and seemed well educated. When it came to planting trees, Steve asked his friend's help in organizing the people in the community. Steve arranged to get the trees from an NGO working on reforestation and his friend said he would organize the people in the community to come and help with the planting. When the time came to plant the trees, no one showed up. He went to his friend's house, but he had gone to the capital. The Volunteer asked around to see what had happened. Several people told Steve that his friend was an outsider and not to be trusted because he had cheated the community last year in a business scheme of his, so no one wanted to get involved with him. What could the Volunteer have done to prevent this outcome?

SESSION PLAN

PART THREE–SESSION 2:

GETTING INVOLVED IN YOUR COMMUNITY

OVERVIEW

The best way to learn about a community is from the inside. While many Volunteers naturally become involved in certain community activities, health Volunteers should make community involvement part of a conscious strategy, both for learning about their community and for laying the foundation for any work they will do with the community. This session asks Trainees to reflect on why it is important to become involved in their community and to think of ways of doing so.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe ways they might become involved in their community.
2. Explain the importance of working with the community on child health activities.

TIME

30 minutes

MATERIALS

Flip chart paper, markers

Handout: *Getting Involved in Your Community*

DELIVERY

STEP 1. Introduce the session as above, and distribute the handout. Be careful not to explain too much about why Volunteers should be involved in their community, as that is the first question on the handout.

STEP 2. Trainees can do this session in groups or on their own. Ask them to take a few minutes to answer the first question. Then solicit their answers and write them on a flip chart. Possible answers:

- to learn more about what goes on in the community
- to learn who key players are in the community
- to meet people and make contacts for the future
- to see how groups operate in this culture
  - to see how decisions are made
  - to see how people organize themselves
  - to see how people plan activities
  - to see how people implement activities
- to demonstrate interest in the community
- to show commitment to the community
- to gain credibility
- to become better known, to be less of a stranger
- to improve language skills
- to improve cross-cultural skills

STEP 3. Ask Trainees to answer the second question and then solicit and record answers as above. Possible answers include:

- Donate your time and services as a volunteer to any organization, public service, or institution that accepts volunteers, including:
  - a hospital or clinic
  - nursing home
  - local charity
  - orphanage
  - any division of the community government
  - the school (where you could tutor children)
  - Boy Scouts
  - Girl Scouts
  - other youth groups

- Join any existing clubs:
    - women's clubs
    - men's clubs
    - sewing club
    - photography club
    - music club
    - garden club
- Become a member of a local sports team
- Become a member of a church congregation
- Join a club run by the church
- Join a church choir or some other kind of choir
- Join an organization associated with your work
- Offer to teach English at the community center
- Offer to teach any skill you have that people might want to learn
- Help to organize some kind of special event, such as:
    - a fund raiser
    - a craft fair
    - a beautification project
    - a construction project
    - cleaning the local library
    - painting the local coop
    - an environmental clean up

STEP 4. Ask Trainees to think about what kind of groups or activities are likely to be especially helpful to them in their role as child health Volunteers. The answers may include:

- groups involving women in one way or another
- groups involving health in one way or another
- more official groups which may have clout in the community
- any activity/group associated with a hospital, clinic, etc.

STEP 5. Ask Trainees how they are going to learn about the various activities going on in their community and the various groups, both formal and informal, that exist. The likely answers here are:

- from people at work
- from their host family or neighbors and friends
- from other Volunteers

STEP 6. Close by reemphasizing how much Volunteers can learn from getting involved, whether they join community activities in order to learn these things or they join just because they have a personal interest in something. Make the point again that if they are not personally inclined to be joiners, then they need to see community involvement as an essential part of their job.

TRAINEE HANDOUT

GETTING INVOLVED IN YOUR COMMUNITY

The best way to learn about a community is from the inside, through participating in one or more community activities. While this kind of participation comes naturally to most Volunteers, those working in community development, such as child health Volunteers, should make community involvement part of a conscious strategy to learn about the community and to become better known to its members.

Try to think of at least three reasons why participating in select community activities will help you in your job as a child health Volunteer:

1. ______________________________

2. ______________________________

3. ______________________________

Now try to think of ways you could become more involved in your community and list some of these below. Consider:

- existing groups or organizations you could join
- other community activities you could participate in
- activities you could do on your own that would bring you into closer contact with the community

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

SESSION PLAN

PART THREE–SESSION 3:
ESTABLISHING CREDIBILITY IN YOUR COMMUNITY

OVERVIEW

When Volunteers first arrive they are strangers; somehow they need to reach the point where the local people accept them, trust them, and are willing to work with them. This session asks Trainees to begin thinking about how they are going to establish their credibility in the community.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain the importance—and necessity—of establishing credibility in their community.
2. Discuss ways Volunteers can establish credibility in their community.
3. Identify obstacles that may exist when a Volunteer is trying to establish credibility.
4. Identify areas where Volunteers may bring credibility to their work/community.

TIME

30–45 minutes (may be longer depending on how many Volunteers participate in the session and what kind of discussion ensues)

MATERIALS

Flip chart paper, markers

Handout: *Establishing Credibility in Your Community*

130

STAFF

Invite the cross-cultural coordinator and HCN staff as well as several current Volunteers to participate in this session.

DELIVERY

STEP 1. Introduce the session by explaining the purpose.

STEP 2. Distribute the handout and ask Trainees to complete Part One on their own.

Quickly go over their answers. Make the point that most Volunteers will answer "NO" to most of these questions (except No. 11). A Volunteer enters his/her community as a relative stranger; it is very important for him/her to become someone the local people are willing to work with and listen to as soon as possible.

STEP 3. To answer the two questions in Part Two, divide Trainees into groups and ask each group to come up with a list of suggestions or observations.

STEP 4. Solicit the observations from each group, recording them on a flip chart.

QUESTION ONE: Here is a list of possible suggestions, with commentary. Add to the flip chart any suggestions that do not appear on the Trainee list.

1. **Keep working at the language.** Your efforts alone will impress people, and the advances you make will impress them even more.
2. **Try your hand at some small task you *know* you will succeed at.** This will establish your basic competence and improve your standing.
3. **Listen, listen, and then listen further.** If you listen to people, they will know you know something—because *they* told you.
4. **Don't try to do too much too soon.** The earlier you try to do something significant, the more likely you will fail.
5. **Spend time with colleagues and co-workers, on and off the job.** As people see you interacting with others—and with them—they'll assume you are learning things about their culture. If, on the other hand, you stay in your house, are only with the other Volunteers in town, or go away on the weekends, they'll assume you're not very interested in them.

6. **Ask questions, all the time, of everyone, as is culturally appropriate.** This is natural as a health volunteer, but it cannot be emphasized enough. The more you know, and especially the more you are seen to know, the more effective you will be.
7. **Work with someone who is credible.** Credibility sometimes rubs off other people who are credible. If you work with people who are known and respected by the community, your own credibility becomes less of an issue.
8. **Try to exhibit as much cultural sensitivity as possible.** Nothing hurts your credibility quite so much as stories about the *faux pas* you have made. And nothing helps it as much as stories about your sensitivity.
9. **Be patient.** The sheer passing of time will work to your advantage; people will get used to having you around and will see you less and less as an outsider.

QUESTION TWO: Add any of the following observations if they do not appear on the Trainees' list.

1. Being associated with the right people or organization may provide instant credibility (because those people or that organization already has credibility).
2. If you live with a family, they may be able to vouch for you.
3. Trying to speak the local language says a great deal about your commitment and good intentions.
4. The fact that you are living in the community will be very helpful.
5. The fact that you live the way the average person does will also be helpful.

STEP 5. Ask the Trainees what obstacles there may be in gaining credibility in the community. For example:

- There may be counterparts who are threatened by your education and experience.
- People may have a negative stereotype of Americans and may see you from this point of view.
- The previous Volunteer may have left on a bad footing.

STEP 6. Ask the participating Volunteers to discuss how they established credibility in their communities, what problems or obstacles they faced, how they dealt with these problems or obstacles, what *faux pas* they may have committed and how they handled them.

STEP 7. Close by observing that it is to become knowledgeable and credible that Volunteers carry out all the data gathering activities they are now learning in training. The reason for doing observations, interviews, time lines, health assessments, and so on, is to gain the knowledge you will need to work effectively in the community.

TRAINEE HANDOUT
PAGE 1 OF 2

ESTABLISHING CREDIBILITY IN YOUR COMMUNITY

PART ONE

Circle "Yes" or "No" for each of the following statements.

1. YES NO I look like most of the people in my community.

2. YES NO I speak the language as well as most of the local people.

3. YES NO I know a great deal about this community.

4. YES NO I know a lot about this culture.

5 YES NO I have spent a good deal of my life in this country.

6. YES NO I know a lot about the health problems in this community.

7. YES NO I know many people in this community.

8 YES NO I have a record of success in this community.

9. YES NO Most people here trust me and my abilities; I am a known entity.

10. YES NO I know how to get things done in this community.

11. YES NO I will be leaving this community after two years.

PART TWO

QUESTION ONE:

This is probably not the first time you have been in a situation like this, where you were the new person, an unknown entity who had to prove yourself to others. Try to think of a similar situation in your past and remember what you did to become accepted. Then think of things you can do as a Volunteer to become more accepted and trusted in your community. List your suggestions and ideas.

1. ______________________________

2. ______________________________

TRAINEE HANDOUT
PAGE 2 OF 2

3. ____________________

4. ____________________

5. ____________________

6. ____________________

7. ____________________

QUESTION TWO:

There are, of course, certain things you have going *for* you as a Volunteer entering a new community, certain ways in which you may have automatic credibility. Some of these are given below. Can you think of others?

1. You have a college education, which is probably highly respected in the local culture, no matter what degree you have.
2. It may be known that you have the technical expertise and/or training to do this job.
3. America is seen as an advanced country in many respects, so Americans are often viewed as people who may have knowledge or experience the host country people do not.
4. You are probably not the first Volunteer in this community. If your predecessors were even partially successful, people may realize that Volunteers can assist them in getting things done.
5. ____________________
6. ____________________
7. ____________________

SESSION PLAN

PART THREE–SESSION 4:
WORKING WITH COUNTERPARTS AND THE COMMUNITY

OVERVIEW

In their roles as community development workers, it is important for Volunteers to understand their personal work styles. It may be easier for Americans to take a direct approach and do the work themselves because of their cultural norms and values. But this does not always have the results they are expecting when working with counterparts and/or communities in a different culture. In this session Trainees study ten different situations and four different ways of handling each situation. Trainees score themselves according to how they would handle these types of situations and then discuss the implications of the four different approaches.

OBJECTIVES

By the end of the session Trainees will be able to:

1. Define the concept of work style and consider differences between various styles.
2. Identify their personal work style.
3. Analyze the implications of their work style in interacting with host country counterparts.

TIME

1 hour

MATERIALS

Culture Matters Workbook

Handouts:

- *Working with Counterparts*
- *The Community Continuum of Volunteer Work Styles*

STAFF

Cross-cultural coordinator.

Invite Volunteers who are currently serving to participate.

PREPARATION

Prior to this session ask the cross-cultural coordinator to attend this session to help with the discussion on cross-cultural implications of work styles. Discuss which exercises in Chapter 4 of ***Culture Matters*** the Trainees should do before this session.

DELIVERY

STEP 1. Explain the purpose of this exercise and distribute the handout *Working with Counterparts and the Community* and the scoring sheet. Ask the Trainees to read the ten situations on their own and score themselves on the scoring sheet according to their first, second, third, and fourth choices.

STEP 2. When everyone is finished, distribute the handout *Continuum of Volunteer Work Styles.* Ask each Trainee to take their highest score and place an "X" on the continuum in the column that corresponds to this score (Column A, B, C, or D).

STEP 3. Ask a Trainee who put an "X" in column A to read the definition. Continue in this manner for the other three columns. Then discuss the implications for each of these work styles in doing community development work. In what types of situations are the various styles most effective? Why?

STEP 4. Ask the participating Volunteers to briefly tell about their experiences working with counterparts, and what differences they have noticed between American and Host Country work styles. How have they adapted their preferential style(s) to their community's customs and needs?

STEP 5. Close by saying that one work style is not necessarily better than another and that, as Volunteers, they may change their style depending on the situation or develop a different style as time goes on.

RESOURCE

Culture Matters: The Peace Corps Cross-Cultural Workbook, Chapters 3 and 4.

TRAINEE HANDOUT
PAGE 1 OF 5

WORKING WITH COUNTERPARTS AND THE COMMUNITY

This exercise is designed to help you assess your own personal work style in handling situations which you are likely to face during your Peace Corps service.

Ten situations typical of those faced by Peace Corps Volunteers in the past are described below. You, as the Volunteer, are provided with four choices in how to handle the situation. Select the ways you think you would feel most comfortable handling each situation and enter your responses on the attached scoring sheet. Assign a "4" to your first choice, a "3" to your second choice, a "2" to your third choice, and a "1" to your last choice.

SITUATION #1

You have just been assigned to a village where you will take over a water sanitation project from a Volunteer who has already left. The project is three years old. You have had brief discussions with the village leaders and you realize that they have mixed feelings about the project. You have been asked to address a meeting of village leaders to introduce yourself. How would you handle the situation? (Respond on the scoring sheet.)

A. Present your approach to the project and ask for questions and advice.

B. Seek the leaders' views of the project and identify problems.

C. Ask the leaders to describe their goals for the project as well as other pressing needs the village is facing.

D. Ask the leaders if you can sit in on this meeting and become better acquainted with the village needs before addressing a meeting.

SITUATION #2

You are a nutrition Volunteer and have been assigned to work with a cooperative that grows vegetables for sale in the market. There is a very high interest in this project among the village at large. However, the local leaders have just decided that all co-op labor must be assigned to re-building the bridge recently flooded out during the rainy season. This is planting time for the vegetable co-op. What do you do?

A. Persuade the leaders to change their priorities, at least to enable the once-a-year planting in the vegetable fields.

B. Help the leaders to identify some alternatives to choosing between the vegetable crop and the bridge.

C. Help the manager of the vegetable co-op develop strategies to try and get the leaders to reconsider.

D. Join in and facilitate the bridge repair in an effort to complete it in time to also plant the vegetables.

TRAINEE HANDOUT
PAGE 2 OF 5

WORKING WITH COUNTERPARTS AND THE COMMUNITY

SITUATION #3

You are in the last six months of your tour. It is unclear whether you will be replaced by another Volunteer. You are in the process of setting up a program to train community health workers in the integrated management of childhood illnesses. The local health committee is very enthusiastic about this program and is urging you to be sure to get it up and running before you leave. You are not sure you can complete it in the time allotted. How will you handle this pressure?

A. Try as hard as you can to complete the project.

B. Lead a planning meeting with the local project committee and staff to discuss and develop alternate strategies.

C. Concentrate on developing skills in the local project staff to enable them to complete the project after your departure.

D. Pass the dilemma on to the local project staff leaders and encourage them to solve the problem and tell you what to do.

SITUATION #4

A new counterpart has been assigned to your immunization project. The new counterpart does not have the connections with the district health officials which the previous counterpart had and seems unable to develop these connections to get the needed vaccines. If you do not get the vaccines soon, your immunization program will fall apart. What will you do?

A. Use your previous associations through the past counterpart to ensure the required vaccines are received on time.

B. Develop a strategy with your new counterpart to provide introductions and contacts to enable the project to get the vaccines on time.

C. Ask your new counterpart to develop a plan to get the vaccines and critique the plan.

D. Encourage your new counterpart to try and figure out how to get the needed vaccines.

SITUATION #5

You are involved in a malaria eradication project. You are working with four teams of health workers who are responsible for carrying out the eradication program in different areas of the district. There is one team that is motivated and knowledgeable about their tasks and has covered almost all of their assigned area. The other teams are not motivated and they are having difficulty completing their projects. The monsoon season is coming and the District Health Officer is predicting a very bad season for malaria. He would like to see the project completed before the rains start. Where will you focus your time?

A. Encourage the teams to complete their work as soon as possible even if they do not do it right, including using the more motivated team as a "model" for the other three teams.

TRAINEE HANDOUT
PAGE 3 OF 5

WORKING WITH COUNTERPARTS AND THE COMMUNITY

B. Balance your time between encouraging the motivated team to complete their work and working with the other three teams.

C. Bring in the other three teams for an in-service training.

D. Identify why the other three teams are not motivated nor knowledgeable about the program and why they are having a hard time completing their tasks.

SITUATION #6

The village you have been assigned to has a beekeeping project about which they are very enthusiastic. Your assignment is nutrition, but you happen to know a bit about beekeeping and see some ways to help improve their already successful project. They have shown no interest in your help. How will you respond?

A. Speak to the community and project leaders, laying out some of your ideas for improving the project and suggesting a change in your assignment.

B. Make suggestions from time to time, informally, demonstrating your competence in this area.

C. Share your dilemma with your counterparts, seek their advice and follow it.

D. Move ahead with your assignment as planned, being alert to any future opportunities to be helpful with beekeeping in an informal way.

SITUATION #7

You are beginning the second year of your service teaching health education in the high school. You have been able to introduce a good health curriculum into the school, including HIV/AIDS prevention. The students and faculty have responded well and have begun to adopt some of the health behaviors you are promoting. Some students in particular have "blossomed" under your direction. What are your priorities for the next eight months?

A. Focus on the blossoming students and try to bring more into the fold.

B. Organize special teacher-training seminars to prepare them to continue with the health education program and to broaden their understanding of the changes adopted.

C. Seek opportunities to co-teach with counterparts to solidify the program and maintain the health behavior changes adopted.

D. Begin planned withdrawal to lessen the dependency on you for sustaining the program.

SITUATION #8

You are a nurse for a community clinic with a very vague and general assignment. There are many areas at the clinic that desperately need your help and you do not know where to begin. The doctor in charge seems glad to have you, but has provided no specific direction. How will you begin?

TRAINEE HANDOUT
PAGE 4 OF 5

WORKING WITH COUNTERPARTS AND THE COMMUNITY

A. Assess your strongest skills and make a concrete proposition to the doctor to clarify your role.

B. Ask for a meeting with the doctor to mutually explore priorities for the clinic and ascertain where you can be most helpful.

C. Ask your counterpart(s) if you can observe them for a month in hope of identifying areas where your skills can complement theirs.

D. Conduct a community needs assessment and develop your role in response to community needs.

SITUATION #9

Your counterparts are becoming increasingly dominating during the community health committee meetings. As their confidence and skill has grown, you have gladly given more responsibility to them, but it seems to you that the other committee members are becoming withdrawn from the project. You want to build a strong project team, rather than just strong counterparts. What should you do?

A. Raise the issue directly with your counterparts and offer to lead the next committee meeting to demonstrate participatory leadership skills.

B. Provide help in planning the next meeting and make some specific suggestions to the counterparts about how to modify leadership behaviors.

C. Watch for opportunities to provide feedback, ask the counterparts questions about how they think the meetings are going, and reinforce participatory behavior.

D. Leave the situation alone and count on the community to call the counterparts on their dominating behavior, and then reinforce your offer to help.

SITUATION #10

Your counterpart is fairly skilled and experienced and moderately interested in your project, but does not see the project as career advancing. The village, however, is extremely interested in the project. How would you handle this situation?

A. Try to get the counterpart reassigned and temporarily take over direction of the project until a new person is assigned to it.

B. Spend time with your counterpart trying to identify ways in which their role in the project can meet both project goals and personal career aspirations.

C. Work with your counterpart trying to identify ways in which their role in the project can meet both project goals, including leaving the project, if appropriate.

D. Facilitate a meeting between community leaders and the counterpart to see if they can come up with a mutually satisfactory solution to the problem.

TRAINEE HANDOUT
PAGE 5 OF 5

WORKING WITH COUNTERPARTS AND THE COMMUNITY

SCORING SHEET

Situation #1	A ________	B ________	C ________	D ________
Situation #2	A ________	B ________	C ________	D ________
Situation #3	A ________	B ________	C ________	D ________
Situation #4	A ________	B ________	C ________	D ________
Situation #5	A ________	B ________	C ________	D ________
Situation #6	A ________	B ________	C ________	D ________
Situation #7	A ________	B ________	C ________	D ________
Situation #8	A ________	B ________	C ________	D ________
Situation #9	A ________	B ________	C ________	D ________
Situation #10	A ________	B ________	C ________	D ________
TOTALS:	**A** ________	**B** ________	**C** ________	**D** ________

INSTRUCTIONS:

Enter your responses for each of the 10 situations. Assign a "4" to your first choice, a "3" to your second choice, a "2" to your next choice, and a "1" to your last choice in each situation.

When you have responded fully to each set of choices, total the number vertically in each column. On the following page is a continuum that defines the four different work styles. Take your highest score and place an "X" on the continuum in column A, B, C, or D. This will show you your preferred work style, based on the situation presented.

CONTINUUM OF VOLUNTEER HELPING/WORK STYLES

Extent to which the community or counterpart is responsible for the work

Extent to which the Volunteer is responsible for the work

A. Direct Service **B. Demonstration** **C. Organizing with Others** **D. Indirect Service**

A. **Direct Service**: This is a direct approach in which the Volunteer does most of the work, gets a project organized, provides a needed service where none exists and generally takes the initiative for making things happen. In most instances, this means that the Volunteer takes responsibility for the action or project, and that a counterpart may or may not get involved, and even if involved, will look to the Volunteer for action and leadership.

B. **Demonstration**: In this approach, the Volunteer spends most of the time demonstrating to others how to do something, but also spends a lot of time doing it him/herself. Most often the responsibility is shared with one or two counterparts. The work is a combination of direct service and training/ demonstration, often with the Volunteer sharing some responsibilities with a promising local leader or counterpart.

C. **Organizing with Others**: By this approach, the Volunteer encourages and stimulates promising counterparts and others in the community, generally—although not always—working with people rather than directly on projects. The focus is on building leadership and helping a group or organization develop which will continue to work after the Volunteer is gone. The primary work is behind the scenes using influence, assisting as a resource in developing alternative solutions which the people choose or generate themselves, serving in a training capacity, occasionally serving as a role model in doing work and so on.

D. **Indirect Service**: In this approach, the Volunteer responds to a range of situations and problems raised by helping others solve their own problems; the Volunteer does not direct any of the work, but concentrates on helping the people define and refine their perceived need. Help is given only on request, rarely initiated by the Volunteer. The Volunteer may even come and go, leaving the project to do something else and thus reinforcing the autonomy of the group. The way the Volunteer works is primarily clarifying, asking questions, listening a lot, and facilitating.

SESSION PLAN

PART THREE–SESSION 5:
CROSS-CULTURAL CRITICAL INCIDENTS

OVERVIEW

Often Volunteers find themselves in difficult situations due to different cultural values. This session asks Trainees to think about some of these complicated situations and practice some responses to them. It is important to have HCN participation in this session to provide the valuable perspective of which responses are culturally appropriate. You may wish to have current Volunteers participate in this session to help with the discussion and to describe the kinds of situations they have experienced.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Illustrate how cultural differences can affect interactions with counterparts and community members.
2. Describe techniques for solving culture-related conflicts or problems with HCNs.

TIME

30–45 minutes

STAFF

Cross-cultural coordinator, HCN staff and current Volunteers

MATERIALS

Handout: *Cross-Cultural Critical Incidents*

PREPARATION

1. Read through the handout. Eliminate incidents that are not issues for your country and add ones that are.
2. If you are going to include current Volunteers, meet with them ahead of time to discuss the objectives of this session and to prep them for their roles. Ask them to come to the preparation meeting with examples of misunderstandings they experienced for cross-cultural reasons and how they dealt with them. Ask them to be prepared to discuss culturally appropriate and effective ways to deal with these situations.

DELIVERY

STEP 1. Distribute the handout and divide the Trainees into small groups. Explain the purpose of this session, and assign each group two incidents. Ask them to discuss each incident in their small groups and come up with recommended responses. Have a facilitator in each group write down the group's responses.

STEP 2. Reconvene the Trainees. Ask the facilitator from each group to present their responses to one of the critical incidents and explain how the group came up with its answer. (There are no right and wrong responses to these critical incidents—it depends on the cultural context.) Ask the participating HCNs and Volunteers to discuss how they might respond in this culture. Continue with the presentation until all the incidents are discussed.

STEP 3. Ask the participating Volunteers to tell about their cross-cultural situations and how they dealt with them. Ask the Trainees if they have found themselves in any similar situations or other settings where appropriate behavior did not seem clear. Discuss effective ways of dealing with them in this culture.

STEP 4. Ask the Trainees to summarize the important points that were raised and how this session may help them in the future.

TRAINEE HANDOUT
PAGE 1 OF 2

CROSS-CULTURAL CRITICAL INCIDENTS

1. CLOSE TO HOME

Part of your job includes working in the local health clinic. The daughter in the family you live with has been sick recently and a certain medication has been prescribed. This morning your host father takes you aside as you are leaving for the clinic and says that he cannot afford the medicine his daughter needs. He says you have access to this medicine at the clinic and asks you to bring him some for his daughter. What do you do?

2. FAMILY TIES

The clinic you work in was set up to help poorer families in the area who cannot afford to pay for health care. Two of the nurses who work here come from large, extended families, whose members do not qualify for treatment at the clinic. Several of the mothers in these families bring their sick children here anyway, and the two nurses always drop what they are doing and give these women preferential treatment. You feel this is an abuse of clinic resources and a misuse of the nurses' time. What do you do?

3. THE EYES DON'T HAVE IT

You have been involved in organizing an eye clinic at the local hospital. You helped the organizing committee draft a proposal that was sent to the Save the Children office in the capital. The proposal was approved two weeks ago and the funds disbursed to the hospital. When you went to the hospital administrator today to inquire about the plans for holding the clinic, he said the funds had not been received. A friend of yours who works in the hospital knows the money has arrived, but has learned that it is going to be spent on new furniture for the administrator's office. What do you do?

4. SIDELINE

You have learned that one of the auxiliary health workers at the clinic where you serve has been stealing medicines from the facility and selling them in town. What should you do?

5. A VACANCY

One of the auxiliary health workers in the clinic you are assigned to has quit, and a replacement is being sought. You have met and befriended a young woman in the village who has all the right qualifications for the job and whom you feel would be an excellent candidate for the position. This morning you approached the clinic director to put in a good word for your friend, only to learn that the director is going to hire her cousin, who has no background in health but was just fired from his job. What do you do?

TRAINEE HANDOUT
PAGE 2 OF 2

CROSS-CULTURAL CRITICAL INCIDENTS

6. NUMBERS

The clinic where you work receives money from the Ministry of Health based on documented clinic usage. Today you were asked to sign a report saying you have seen twice as many patients as you have actually seen. What do you do?

7. SAVE THE TREES

Since you arrived in your village, you have been doing health education sessions on the importance of boiling drinking water. Last week you were approached by an influential community leader who suggested that your talks are jeopardizing a grant the community was going to receive from an international environmental organization. This organization certifies that the amount of deforestation in an area has decreased and gives the villages involved a cash reward. The leader has said that because of your talks, the village women are cutting down too many trees and the grant may not be awarded. What should you do?

PART FOUR: UNDERSTANDING THE SETTING

INTRODUCTION

Whatever their particular job assignment, one of the first things Volunteers should do when they reach their site is to educate themselves as completely as possible about their community, both in general and about child health in particular. In short, they need to gather information. How to gather information and data is the focus of this section of the manual, with special emphasis on two kinds of information:

- information about the community itself
- information about child health-related beliefs, practices, and conditions

Information gathering is also important for Volunteers who are not working in health, but are planning to undertake some kind of health activity outside of their specific job assignment. It is often the case that a Volunteer assignment includes organizing or helping others to organize child health initiatives or projects.

SUMMARY OF SESSIONS

SESSION 1:	**Framework for Community Analysis** introduces the child health notebook which is a tool for Trainees to use to structure their data gathering and especially to organize their findings.
SESSIONS 2.1–2.3:	**Designing a Community Mapping Tool, Mapping the Community, and Processing the Mapping Exercise** are three sessions which focus on general information about the community, not health information in particular.
SESSION 3:	**Description vs. Interpretation** introduces the concept of cultural filters that affect interpretation of what one sees.
SESSIONS 4.1–4.3:	**Developing Observation Tools, Observation and Processing Community, Home, and Clinic Observations** are three sessions that focus on gathering child-health related information through observations in three settings: the community at large, homes, and clinics.
SESSION 5:	**Styles of Communication** prepares Trainees for the next four sessions on interviewing by having them consider various cultural differences in communication styles, especially ways to ask for information in the local culture and how to understand the answers.
SESSIONS 6.1–6.4:	**Writing Interview Questions; Developing Interview Tools; Interviewing in the Community, Home, and Clinic; and Processing Interview Information** focus on interviewing for child-health related information.
SESSIONS 7.1–7.2:	**Time Line of Daily Activities** and **Processing the Time Line of Daily Activities** teach how to produce a time line as a way to gather information on the daily routine of a mother and/or a health worker and how this daily routine may have an impact on designing and carrying out health interventions.
SESSIONS 8.1–8.2:	**Child Health Assessment and Processing the Child Health Assessment** gives the Trainees hands-on experience in actually doing a child health assessment using the Integrated Management of Childhood Illnesses (IMCI) tools introduced in the session **Assessing the Sick Child: Case Studies**, p. 65.
SESSIONS 9.1–9.2:	**Looking at Child Health Records and Processing the Information Gathered from Clinic Records** present yet another tool for gathering health information.

WHEN SHOULD THESE SESSIONS BE DONE?

These sessions should be done after Trainees have completed Part Two: Fundamentals of Child Health and before they begin Part Five: Addressing Child Health Issues. To ask Trainees to gather information before they understand the basics of child health would not be very productive. Similarly, to ask them to think about addressing child health problems before they understand the problems and health conditions would not be productive either.

ADDITIONAL TOOLS FOR YOUR REFERENCE:

The ***Gender and Development Training Manual*** (Booklets Four and Five), ***Promoting Powerful People: A Process for Change***, and the ***Community Risk Assessment Tool Box: A Manual for Peace Corps Volunteers Working with Micronutrients*** contain additional tools for gathering information. These include such tools as conducting focus groups and seasonal calendars.

Culture Matters: The Peace Corps Cross-Cultural Workbook provides related sessions and important cross-cultural concepts.

SESSION PLAN

PART FOUR–SESSION 1:

FRAMEWORK FOR COMMUNITY ANALYSIS

OVERVIEW

As Trainees begin the community entry process, they will be looking at and analyzing the assets within a community, health needs/ problems in a community, and the factors that create these needs or problems. They will be looking at this information *with* the community and seeing it from the community's point of view. Later they will use this information to work with the community in developing appropriate and feasible interventions. This session introduces the framework for data collection and analysis.

OBJECTIVE

By the end of the session the Trainees will be able to explain and use a framework for organizing and categorizing child health data.

TIME

20–30 minutes

MATERIALS

Flip chart paper, markers

Child health notebooks (sturdy, blank notebooks)

DELIVERY

STEP 1. Explain to the Trainees that before they can begin working with community members on any kind of health project, they need to begin to understand the assets within a community, health needs/problems in a community, and the factors that create them.

STEP 2. Give each Trainee a child health notebook. Explain to them that during the first phase of training they will be gathering information from various sources, using different information gathering tools, and recording that information in this notebook. Later they will be using this information to work with the community in developing appropriate interventions.

STEP 3. Write these categories on a flip chart and define them as follows:

A. Community assets

B. Child needs/health problems

C. Factors affecting child health needs/problems

A. Assets are the existing strengths and resources of a community that it can build on or use in implementing any kind of child health activity or program. Types of assets include:

- **groups of people** and/or existing organizations who come together for any purpose, including formal organizations (government/NGO programs, women's clubs, co-ops, youth groups, health campaigns, etc.) or informal groups (planting/harvesting, collecting water/fuel, social functions, etc.)
- **successful projects/programs** (i.e., what is working well in the community.)
- **individuals** who have specific knowledge, education, skills, positions (i.e., government workers, community leaders, doctors, nurses, health workers, traditional birth attendants (TBAs, mothers, etc.)
- **facilities and services** (hospitals, clinics, schools, lending organizations)
- **things** (food, clean drinking water, money)

Point out to the Trainees that identifying assets includes looking at what is working in a community and analyzing why this is so. For example: children do not suffer from diarrhea because there is a clean water source; or the children get fewer respiratory infections than in other communities because they have been immunized against measles, or the kitchens are equipped with smokeless fireplaces; or there is a lower rate of malaria because the houses have screening and the families sleep under mosquito nets.

Later Trainees will look at what motivated the community to implement these prevention programs and see how this can be applied to other interventions.

B. **Child health needs/problems** refers to childhood illnesses and conditions such as:

- malnutrition
- respiratory infections
- diarrhea/dehydration
- measles
- malaria
- intestinal parasites
- eye and ear infections
- skin infections
- tuberculosis
- polio
- diphtheria, tetanus, whooping cough
- cholera
- dengue fever
- typhoid
- chickenpox and mumps

C. **Factors creating or affecting** child health needs or problems include:

- **immediate** causes – the direct or nearest (sometimes called proximate) cause of a problem, usually the result of an ultimate cause, such as:
  - contaminated water or food
  - poor diet
  - being exposed to contagious diseases
  - being bitten by mosquitoes carrying malaria or dengue fever
  - poor sanitation
- **ultimate** causes – a more distant or fundamental cause of a problem, frequently the explanation behind an immediate cause, such as poor sanitation (which results in flies landing on feces and then contaminating exposed food). "Ultimate" does not necessarily mean a first cause, but rather a cause more removed and indirect than an immediate one.

Examples:

- contaminated water or food
- lack of latrines
- unavailability of nutritious foods
- poverty/lack of money to buy nutritious foods
- poor soil conditions for growing needed foods
- poor living conditions/sleeping in crowded rooms
- no screens on windows and doors
- unavailability of or no money to buy mosquito nets
- lack of water for bathing or washing hands
- children don't wear shoes (exposing them to hookworm)
- no money to buy shoes
- lack of knowledge or understanding how to prevent illnesses

Clarify the difference between a problem and a factor contributing to a problem. For example, drinking water in itself is not a health problem, but it may be a contributing factor to diarrhea because it is contaminated.

STEP 4. Tell the Trainees that they will be keeping track of information they gain in their notebooks. They may choose to divide their child health notebook any way that is helpful to them. One way is to divide it into four parts, making three of the sections for each of these categories (assets, needs/problems, and factors) and a fourth section for general notes, observations, ideas, and other activities.

STEP 5. Ask the Trainees to think about an asset, a problem and a factor that might be affecting the problem that they may have seen in the communities where they are living. Ask them to begin their notes with these examples. Discuss several Trainees' entries. Make sure all Trainees are clear on the difference between assets, problems, and factors as they are used here.

STEP 6. Close by repeating that the point of this exercise was to clarify terms and to present the framework which Trainees will be using for the purpose of collecting and recording information and, later, as a means for analyzing the data they have collected.

SESSION PLAN

PART FOUR–SESSION 2.1:

DESIGNING A COMMUNITY MAPPING TOOL

OVERVIEW

This session introduces the Trainees to the technique of community mapping as a first step in getting to know their community.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain the community mapping concept.
2. Design a community mapping tool.

TIME

1 hour

MATERIALS

Flip chart paper, markers

PREPARATION

In ***Gender and Development Training*** read pages 3–17 in Booklet 5 and pages 20–37 in Booklet 8. These pages discuss in detail several different ways to approach this community mapping exercise. The specific goal of the activity is to teach the Trainees how to map a community and why this skill is important, but the mapping activity also provides an opportunity to demonstrate how significantly maps may differ depending on who has mapped the area.

DELIVERY

STEP 1. Explain to the Trainees that the session will focus on mapping a community. Ask the Trainees to brainstorm why mapping is an important activity for newcomers to a community. List their ideas on a flip chart.

STEP 2. Ask each Trainee to draw a map of the neighborhood in which she/he grew up. Give them 15 minutes in which to do so. Then, in pairs, have them explain to their partners why they chose to map the things that they drew.

STEP 3. Ask the whole group to identify some of the things they represented on their maps. They should include various kinds of information such as institutions, infrastructure (such as roads), and relationships.

STEP 4. Ask them to look back at the list they made in Step 1. Are there things they listed that they did not represent on their maps? Could they include them? How? Did this exercise make them more aware of other information that maps can reveal?

STEP 5. With the Trainees, decide which geographical area of the community they will map. If it is a small community, they can all map the same area. If it is a large or urban community, they can divide into groups and map different areas. If the Trainees are living in different communities, they may choose to map their own individual community.

STEP 6. Discuss the following options with the Trainees and ask them to decide how they would like to conduct the activity. Ask them if they have other suggestions as to how to form the work groups.

Options:

1. Groups divided by Trainee Gender

   The Trainees can divide themselves into same sex groups and create maps of the community.

2. Groups divided by Nationality

   Groups of Trainees and groups of Host Country Nationals could draw maps of the same community.

3. Groups divided by Age

   Groups of Trainees could ask HCNs of different ages to guide them on a tour of the places in the community which they consider important.

STEP 7. Tell the Trainees that they may ask a language trainer or a member of their host family to accompany them. Being accompanied by someone local introduces the idea that the Trainees should be working collaboratively with the HCNs at all times, including gathering information.

STEP 8. Tell the Trainees how long they have to accomplish this task.

RESOURCES

Sessions on community mapping can be found in both ***Promoting Powerful People: A Process for Change*** and Booklet #5—"PACA Tools"—from the ***Gender and Development Training Manual***.

SESSION PLAN

PART FOUR–SESSION 2.2:

MAPPING THE COMMUNITY

OVERVIEW

During this session the Trainees walk through a community and draw their maps.

OBJECTIVE

By the end of the session the Trainees will be able to conduct a community mapping activity.

TIME

2 to 3 hours depending on size of community to be mapped.

MATERIALS

Flip chart paper
Different colored markers

PREPARATION

Prior to this session meet with the leaders in the community and explain to them what the Trainees will be doing, why, and when. Obtain their permission if necessary. Then have the Trainees introduce themselves to the community leaders before they start mapping the community.

159

DELIVERY

STEP 1. Have Trainees map the community in groups determined in previous session (1-1 1/2 hours).

STEP 2. As they finish, they should return to the training room and draw their maps on sheets of flip chart paper. They should label their maps by their groups and the area mapped (1/2-1 hour, as needed).

160

SESSION PLAN

PART FOUR–SESSION 2.3:

PROCESSING THE COMMUNITY MAPPING EXERCISE

OVERVIEW

In this session the Trainees process the information they gathered in the community mapping exercise. They will also begin to look at and analyze assets, problems, and contributing factors of the community.

OBJECTIVES

By the end of this session the Trainees will be able to:

1. Discuss the impact which different peoples' perspectives can have on a community map.
2. Discuss the data they gathered in their community mapping activity, including assets and potential needs of the community.
3. Begin to identify the implications of this data for child health.

TIME

45 minutes

STAFF

Invite the language trainers and/or other host country national staff to participate in this session and ask them to give their input and perspective as the Trainees process their experiences.

MATERIALS

Flip chart paper, markers

161

PREPARATION

Prior to this session ask the groups to draw their maps on large pieces of paper and post them in the classroom.

DELIVERY

STEP 1. Ask Trainees and invited guests to walk around and look at all the maps.

STEP 2. Begin the session by asking the Trainees to describe what the experience was like for them. Ask what was easy about the exercise and what was difficult.

STEP 3. Have representatives of each group describe how they approached gathering the data for their maps. How did they decide what to represent?

STEP 4. Ask the Trainees to discuss possible reasons why the maps are different. Depending on the way the groups were formed, ask the Trainees to discuss:

- How do men perceive their community and how do women perceive their community? What factors may contribute to any differences in their perceptions?
- Did HCNs in their group identify or remark on different things than the Trainees did? Why might this have happened?
- What differences are there in the way community members of different ages view the community?
- What are the implications of these different perspectives on the community?

Help Trainees to reach the conclusion that no one person has all of the information, and that the broadest picture incorporates various perspectives.

STEP 5. Lead a brief discussion (using the sample prompt questions below) on how the physical layout of the community might affect health practices. If needed, use some of these questions as prompts:

- How far from the homes are services such as wells, clinics, and schools?
- Who lives in the center of town and who lives on the edge of town?
- How far away are the fields where the farmers work?
- Did you notice if there was a proper sewage system? Were the streets clean?

162

- Was electricity available to all? If not, who had it and who didn't?
- What type of fuel did most people use? If wood, how far did the people have to go to get it?

STEP 6. Ask the Trainees if they observed any assets of the community during this exercise. How might some of these relate to the health of community members?

STEP 7. Remind the Trainees that as Volunteers they would be doing this mapping activity with a counterpart or someone from the community. Ask the Trainees who in the community they might do this activity with and how would they get them involved.

SESSION PLAN

PART FOUR–SESSION 3:
DESCRIPTION OR INTERPRETATION?

OVERVIEW

In a cross-cultural setting, it can be dangerous to interpret the facts, because we inevitably do so from our own cultural point of view. If you are observing the behavior of a host country person, that behavior should be interpreted from the host country culture's point of view. This session illustrates how description, a mere statement of what one sees without attaching meaning to it, is different from—and normally safer than—interpretation. The message is not that Volunteers should never try to interpret what they see around them, but that they should try to do so from the local point of view.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain the differences between description and interpretation.
2. Discuss the risks and dangers involved in interpretation in a cross-cultural context.

TIME

15–20 minutes

MATERIALS

Handout: *Description or Interpretation?*

DELIVERY

STEP 1. *Introduce the session using the overview above.*

STEP 2. Distribute the handout and ask trainees to complete it.

STEP 3. Discuss the handout with Trainees. For each pair of statements, ask someone to explain why the statement labeled "I" for interpretation could be inaccurate.

STEP 4. Close by asking the group if anyone can think of an interpretation they have made thus far in-country that might, in retrospect, have been incorrect.

ANSWERS:

The correct responses for each pair are as follows:

1. I, D **2.** I, D **3.** D, I **4.** I, D **5.** I, D
6. D, I **7.** D, I **8.** D, I **9.** I, D **10.** D, I

Trainee Handout

Description or Interpretation?

Read each of the following pairs of statements and put a "D" next to the one which is a Description (a statement of the facts) and an "I" next to the Interpretation (drawing a conclusion from the facts).

1. ____ That health worker doesn't know about disease prevention.
1. ____ That health worker told the mother to make an offering at the temple.

2. ____ The doctor at the clinic is power hungry.
2. ____ The doctor at the clinic doesn't share information with his health workers.

3. ____ That mother didn't do what I told her.
3. ____ That mother didn't believe me when I told her she should boil her drinking water.

4. ____ That family doesn't understand about good nutrition.
4. ____ That family doesn't buy fruits and vegetables.

5. ____ That health worker is lazy.
5. ____ That health worker doesn't do anything without being told by her boss.

6. ____ That family has five children.
6. ____ That family doesn't believe in family planning.

7. ____ That mother didn't use the medicine she was given at the clinic.
7. ____ That mother doesn't believe in modern medicine.

8. ____ That mother never comes to the clinic.
8. ____ That mother isn't interested in the health education talks we give at the clinic.

9. ____ That mother favors her male children.
9. ____ That mother treats her female children differently than her male children.

10. ____ The floor in that house is made of cow dung.
10. ____ The floor in that house is unclean.

SESSION PLAN

PART FOUR–SESSION 4.1:
DEVELOPING OBSERVATION TOOLS

OVERVIEW

Observation is one of the most important skills that Volunteers can have to gather information. In this session, the Trainees develop tools for making observations in the community, the home, and the clinic. These are used in the next session when they will actually go out and make observations.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain the technique of observation.
2. Design observation tools for use in a home, at a health facility, or in the community.

TIME

30 minutes

MATERIALS

Handout: *Observation Tool*

Flip chart paper and markers

DELIVERY

STEP 1. Briefly describe the purpose of this session to the Trainees and explain that observation is a skill that they will be using throughout their service to gather information.

When the Trainees are still learning a language, observation will be particularly important because they will not be able to talk to people about what they know or believe in much detail. Later on, observation will help the Trainees to focus on specific health-related actions and compare what people *say* they do with what they *actually* do in their daily lives.

STEP 2. Divide the Trainees into three groups. Assign one group to develop a list of activities and things to look for in the *community*. Use the following categories as a guide:

- Water, Sanitation, and the Environment
- Food and Fuel
- Non-Food Items
- Services
- Socio-economic

The second group should develop a list of activities and things to observe in the *home* using the following categories:

- In the Kitchen
- In the Living Area
- In the Area Surrounding the Home
- Socio-economic

The third group should develop a list of activities and things to observe in a *clinic* setting using the following categories:

- Staff
- Services
- Medicines, Supplies, and Equipment

STEP 3. Distribute the handout *Observation Tool* and ask each group to brainstorm a list of activities and things they should observe in their assigned setting. Ask each group to fill out the section of the handout that applies to their setting and to select a facilitator/group leader to write the lists on a flip chart. Give them some examples from the lists below to get them started.

STEP 4. Give the groups ten minutes to complete the exercise. Visit each group to make sure they understand the assignment and answer any questions.

STEP 5. Reconvene the groups and ask each facilitator to share their list. Discuss the lists and ask the entire group if they have any additional observations to add to each list. If anything from the observation lists does not apply to your country, delete it.

STEP 6. If you do not plan to meet with the Trainees before they go out to do their observations, then do Steps 1–6 from the session ***Observation Exercise***, p. 154 now.

RESOURCES

The ***Gender and Development Training Manual***, Booklet #4, and ***Promoting Powerful People*** have related sessions on observation skills.

TRAINEE HANDOUT
PAGE 1 OF 6

OBSERVATION TOOL

In this session you will be working in a group to develop a list of activities and things to observe in one of three different settings: the community, the home, or the clinic. Each setting has categories for organizing your information. Examples of things to observe are given under each category. Do not merely look for "things", but also for who is doing what and how is it being done; observe for cleanliness and cost of things; look at people interacting, etc. In your group you will be filling out only one of these three sheets, the contents of which your group leader will then present to the other Trainees. As the other group leaders present the lists their group compiled, for the other two settings, make notes on the remaining two sheets.

TRAINEE HANDOUT
PAGE 2 OF 6

OBSERVATION TOOL

IN THE COMMUNITY:

Water, Sanitation, and the Environment

- What is the source for drinking water (piped into people's homes, a communal well, outside tap/communal tap, river/stream)?
- What containers are used to collect the water?

Food and Fuel

- What is the staple diet in this community?
- What fresh fruits and vegetables are available?

TRAINEE HANDOUT
PAGE 3 OF 6

OBSERVATION TOOL

Non-food Items

- Are there shops that sell clothing, shoes, material for making clothes, etc.?
- What is the average cost of these items?

Services

- Is there a telecommunications center?
- What types of transportation services are available?

Socioeconomic

- What are the characteristics of the community (ethnic groups, evidence of economic level, etc.)?
- What types of occupations do you observe?

TRAINEE HANDOUT
PAGE 4 OF 6

OBSERVATION TOOL

IN THE HOME:

In the Kitchen

- What foods do you see?
- How are they stored (open to contamination, in closed containers, up off the ground)?

In the Living Area

- Where does the family gather?
- Are there screens on the doors and windows?

In the Area Surrounding the Home

- Is it clean around the house?
- How does the family dispose of their garbage?

173

TRAINEE HANDOUT
PAGE 5 OF 6

OBSERVATION TOOL

Socioeconomic

- Who lives in the household?
- *How many children does this family have?*

IN THE CLINIC:

Staff

- Who staffs the clinic?
- What are their qualifications?

Services

- Who comes to the clinic?
- For what reasons?

TRAINEE HANDOUT
PAGE 6 OF 6

OBSERVATION TOOL

Medicines, Supplies, and Equipment

- What medicines are available?
- *Where are they stored?*

SESSION PLAN

PART FOUR–SESSION 4.2:
OBSERVATION EXERCISE

OVERVIEW

In this session the Trainees gather information from the community and a clinic using the tools they developed. The Trainees can do their observations in the home in the evening with their homestay families. If they are not with homestay families, arrangements need to be made to visit some homes.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Conduct an observation activity.
2. Make observations.
3. Explain the difference between describing and interpreting observations.

TIME

4 hours

PREPARATION

Meet with the clinic supervisor or staff prior to this session to introduce yourself and Peace Corps, explain the purpose of this activity, and ask permission to attend the clinic for observation. Arrange a time that would not interfere with the clinic staff, but also when there are clinic activities going on.

If you do not plan to meet with the Trainees prior to their doing this session do the following steps at the end of the session on **Developing Observation Tools**, p. 145.

DELIVERY

STEP 1. Tell the Trainees that they will be doing an observation exercise in each of the three settings using the tools they have developed. If you have a large group of Trainees (more than ten) do this exercise in two parts: For the first half of the time allotted, have half of the group make their observations in the ***community*** and the other half make observations in the ***clinic***. Tell them they have two hours to complete this part of the exercise. During the second half of this exercise, switch the groups so that those who made observations in the community will go to observe the clinic and those who were at the clinic will now go to observe the community.

Trainer Note: *Observation is usually best done as an individual exercise rather than in a group, but this may not be feasible or practical. If done as a group exercise, make the groups as small as possible. To avoid their observations from being influenced by others in the group, ask the Trainees to minimize any discussion during the actual observation activity. Better still, ask them not to discuss their observations until after the exercise is finished.*

STEP 2. For the community observation, you might divide the Trainees into four small groups and assign each a category of things to observe: 1) food and fuel, 2) water, sanitation, and the environment, 3) non-food items, and 4) services and socio-economic. Or you could assign the Trainees to a certain locale in the community such as the well or water gathering place, the market place, the bus station, or the town square where they can observe all the activities going on.

STEP 3. For the clinic observations ask the whole group to observe all categories.

STEP 4. Tell the Trainees that observations in the ***home*** can be done with their homestay families in the evening. If the Trainees are not staying with families, then arrange for them to go into several homes in the community near the training site to complete this exercise. If at some point during the PST Trainees will be staying with a family for a short period, then the home observation part of this exercise can be done at that time.

STEP 5. Ask the Trainees to note the time of the year, the day of the week, and the time of day that each observation is being made. It is important to note that different activities happen on different days at different times of the day, and at different times of the year. (Even though the Trainees will not be able to compare activities at different times of the year, you could discuss what these might be during the processing of this exercise.)

STEP 6. Ask the Trainees to record their observations and time frames in their child health notebooks.

STEP 7. Refer back to the session **Description or Interpretation**, p. 142, and remind the Trainees to try and avoid making interpretations about their observations. Their task is to simply describe what they see.

STEP 8. Send the Trainees out to make their observations.

RESOURCE

Handout: *How to Use Observation to Learn About Your Community* from ***Promoting Powerful People: A Process for Change***, section II, session 4.

SESSION PLAN

PART FOUR–SESSION 4.3:

PROCESSING THE COMMUNITY, HOME, AND CLINIC OBSERVATION EXERCISE

OVERVIEW

In this session the Trainees process the information they gathered in the community, home and clinic observation exercise. They add to their lists of community assets, child health needs/problems, and contributing factors which they had begun in the session **Framework for Community Analysis**, p. 130.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss the results of their observations.
2. Discuss the implications of the data they have gathered.
3. Record their observations in their child health notebooks.

TIME

1–1.5 hours.

Note to Trainer: *Because there is a lot of information to process from the observation exercises in the community, home, and clinic, you may wish to divide this exercise into two or even three sessions.*

MATERIALS

Flip charts, markers

STAFF

Invite the language trainers and/or other host country national staff to participate in this session and ask them to give their input and perspective as the Trainees process their experiences.

PREPARATION

Prior to this session ask one Trainee to write the list of observations made in the community on a flip chart. Ask a second Trainee to do the same for observations made in the home, and a third Trainee to do likewise for observations made in the clinic. These lists should be divided into the categories they were given in the Session 4.1 Developing Observation Tools. These flip charts will be helpful in expediting the small group work.

DELIVERY

STEP 1. Begin by asking the Trainees to describe two important things that they learned from each of the community, the home, and the observation exercises.

STEP 2. Divide the Trainees into three groups. Tell the Trainees that one group will work on community observations, the second one on home observations, and the third one on clinic observations. If you have a small number of Trainees, then divide them into two groups and have one group work on community observations and the second one on home and clinic observations.

Each group should begin by looking at the flip chart created by the individual Trainee prior to this session that corresponds to their assigned task and add anything they see missing to the list. Then have them identify *assets* from the list and write these on a separate flip chart. They should do likewise for *health needs/problems* and *contributing factors*. Give them 20–30 minutes for this exercise.

STEP 3. Bring the groups back together and have a Trainee from each group read out the three lists. Have the participants look at the lists and comment on any overlaps. For example, the group who processed the community observations may find availability of fruits and vegetables on the assets list as well as on the contributing factors list because they are seasonal which may contribute to malnutrition or vitamin deficiencies. The group who processed the home observations may find drinking water is piped into the home on the assets list as well as on the contributing factors list because the pipe bringing the water into the home is old and rusty and contains cracks whereby contaminants from the ground get into the water. The group who processed the clinic observations may find staff on the assets list as well as on the contributing factors list because the staff don't take the time to educate the patients on how to take their medicines properly.

STEP 4. While the Trainees are listing and discussing their observations, ask them to look out for observations or comments that might be "interpretative" rather than "descriptive." You should do likewise. Process those observations that are interpretations with the group so that they become aware of the fact that they are "interpreting" rather than giving a "description" of their observations. One way to do this is have them rewrite an interpretation to make it an observation.

STEP 5. Remind the Trainees that as Volunteers they would hopefully be doing this observation activity with a counterpart or someone from the community. Why would that be useful? Ask with whom in the community they might do this activity and how they might get the person involved.

STEP 6. Wrap up the session by suggesting that they might want to note any additional assets, needs/problems, and contributing factors in notebooks as they will use the data later.

SESSION PLAN

PART FOUR–SESSION 5:
STYLES OF COMMUNICATION

OVERVIEW

Up to this point, Trainees have gathered information through observations. In the exercises that follow, they will be gathering information through interviews and verbal interactions with mothers, health workers, and other community members. Therefore, they need to understand communication in the cross-cultural context in order to minimize misunderstandings and misinterpretations.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain several key communication concepts.
2. Identify important cultural differences concerning these concepts.
3. Discuss the implications of these differences for data gathering in the community.

TIME

15–20 minutes

MATERIALS

Culture Matters: The Peace Corps Cross-Cultural Workbook

Culture Matters Trainer's Guide

STAFF

Cross-cultural coordinator

PREPARATION

Prior to this session meet with the cross-cultural coordinator to explain the purpose of this session. Together review the session outline and determine which concepts in Step 2 are important to spend time on. Ideally, the cross-cultural coordinator will co-facilitate this session with you using the ***Culture Matters Trainer's Guide***.

Ask the Trainees to complete the exercises in chapter three of ***Culture Matters***, if they haven't already done so. They should do this on their own time.

DELIVERY

STEP 1. Explain the purpose of this session and tell the Trainees that in the following sessions they will be writing interview questions, developing an interview tool, and carrying out interviews in the community. Before learning about interviewing techniques, however, it is important to explore some cross-cultural communication topics.

STEP 2. Discuss the following key communication concepts with the Trainees using the ***Culture Matters Trainer's Guide***:

- Indirect and Direct Communication
- High and Low Context Communication
- Task vs. Person Orientation
- Nonverbal Communication–gestures, eye contact conversational style, facial expressions, personal space, and touching
- Harmony and Saving Face

STEP 3. Ask the Trainees to identify any important cultural differences concerning these concepts which they have already encountered. Write their comments on a flip chart.

STEP 4. Discuss the implications of these differences for data gathering in the community, especially when interviewing or talking with community members, and record these implications on a flip chart.

RESOURCE

Culture Matters, The Peace Corps Cross-Cultural Workbook

Culture Matters Trainer's Guide

SESSION PLAN

PART FOUR–SESSION 6.1:

WRITING INTERVIEW QUESTIONS

OVERVIEW

This activity presents the four major types of interview questions and asks Trainees to consider the strengths and weaknesses of each. After this session Trainees are prepared to produce useful questionnaires in the next session.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss the advantages and disadvantages of various types of interview questions.
2. Write different types of interview questions.

TIME

15–20 minutes

MATERIALS

Handout: *Types of Questions*

DELIVERY

STEP 1. Explain to the Trainees that there are four types of questions which are important to interviewing: closed questions, open-ended questions, leading questions, and exploratory questions. Ask for examples of each or use the following examples of each type of question and discuss the characteristics of each one.

Closed questions generally are answered with a "yes" or "no" or another one-word answer which does not tell you much about what people believe in, think, or do, and why.

Examples: Do you take sugar with your tea?

How many children do you have?

Open-ended questions allow people to talk more about what they think, do or feel. They typically begin with the words why, how, what, or phrases such as "Tell me about...", "Explain to me...", or "Describe..."

Examples: "Why don't you drink orange juice when you have a cold?"

"What happened in the meeting today?"

Leading questions "lead" people to give the answers that they think you want them to give. They begin with phrases such as "Don't you think that...", "Don't you agree that...", "Isn't it right that...", "I think such and such, what do you think?"

Examples: "Don't you agree that women should stop breast-feeding when their babies are one year old?"

"I think we should have a latrine building project. What do you think?"

Exploratory questions help you find out more about what a person is saying. These types of questions come in several forms:

Repeating the person's words as a question, for example, a mother says to you "I think bananas would improve my child's diarrhea. To explore further, you ask "Why do you think bananas would help your child's diarrhea?"

Asking the person to explain further, for example, "I'm not sure what you mean", "You mentioned something about...", "You started to say something about... Tell me more about it."

Asking the person to place him/herself in the position of somebody else, i.e., "Suppose a woman is pregnant, what foods do you think she should eat?"

Remaining silent is also a useful way to help another person to talk more about a subject under discussion. It gives the person time to think about what they want to say or to consider different things they could tell you about.

STEP 2. Distribute the handout *Types of Questions* and ask the Trainees to fill in the answers. Give them five minutes to complete this exercise.

STEP 3. Review and correct their answers on the handout. See answers below.

Answers:

1-C, 2-O, 3-L, 4-C, 5-E, 6-L, 7-O, 8-E, 9-C,

10-O, 11-O, 12-E, 13-L, 14-C, 15-O

STEP 4. Lead a brief discussion of the pros and cons and appropriate uses of each of the four types of questions. For each type ask:

1. What are some good uses of this type of question?
2. What are its drawbacks or limitations?

STEP 5. Now ask the Trainees to write their own examples of a closed question, an open-ended question, a leading question, and an exploratory question. Discuss their examples as a group.

STEP 6. Advise the Trainees that, in developing their interview questions in the next session **Developing an Interview Tool,** p. 166, they should use more open-ended rather than closed questions. While they may begin their interviews with a closed question or two as they are often easier for the interviewer to answer, they should then ask open-ended questions. Tell the Trainees not to use leading questions because they do not allow the person being interviewed to tell what they really know or think; rather, they encourage the person to agree with you or to say what they think you want to hear. Exploratory questions help you to clarify or explore more about what a person has said. They encourage a person to talk more about a subject.

RESOURCE

Promoting Powerful People: A Process for Change, Section II, Session 6, and ***Gender and Development Training Manual***, Booklet 4

TRAINEE HANDOUT

TYPES OF QUESTIONS

Read and label each of the following questions by their type:

O for an **open-ended** question
C for a **closed** question
L for a **leading** question
E for an **exploratory** question

1. ________ Do you breast-feed your baby?
2. ________ What do you feed your baby when he has diarrhea?
3. ________ Don't you think you should go to the clinic when your baby is ill?
4. ______ Do you use the health clinic?
5. ________ You mentioned something about weaning foods. Tell me more about that.
6. ________ Shouldn't you boil your drinking water?
7. ________ What do you think causes fever?
8. ________ What do you mean by that?
9. ________ How many times a day do you feed your baby?
10. ________ Please tell me about your child's favorite foods.
11. ________ Are there any foods your child refuses to eat?
12. ________ Your child refuses to eat rice?
13. ________ Don't you give the child eggs to eat?
14. ________ Is your child immunized against measles?
15. ________ What immunizations has your child had?

SESSION PLAN

PART FOUR–SESSION 6.2:

DEVELOPING AN INTERVIEW TOOL

OVERVIEW

This session introduces a new tool for gathering information: one-on-one interviews. This tool is used to add to the information already gathered through community mapping and observations. Interviews allow Trainees to begin to understand how members of the community see their assets, local health problems, the causes of the problems, and what they do—or think should be done—to treat and prevent these problems.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss the interview as a data gathering tool.
2. Design an interview tool for use in the community.

TIME

45 minutes

MATERIALS

Flip charts and markers

STAFF

Language coordinator and language trainers

PREPARATION

Prior to this session meet with the language coordinator and explain the purpose of this session. Ask the language coordinator or one of the language teachers to attend the session. The language person can assist the Trainees in developing their interview questions. Ask the language coordinator to integrate these questions into language class in order to give the Trainees an opportunity to practice asking these questions in the local language before they do their interviews.

DELIVERY

STEP 1. Tell the Trainees that they will be developing questions for one-on-one interviews and will be carrying out interviews in the following session. In general, they will be formulating questions about community assets and about health needs, problems, and practices in the home, in health care settings, and in the community.

STEP 2. Divide the Trainees into three groups. One group will develop questions for interviews with mothers; one will develop questions for interviews with health care workers; and one will develop questions for interviews with a community leader.

STEP 3. Ask each group to brainstorm a list of questions they would ask in their interviews and write these on a flip chart. As they do so, they should think back to (or refer to) the information gathered in their observations and include questions on any topics they want to follow up on or learn more about. You may give Trainees some general categories to help trigger their questions but they do not have to limit themselves just to these areas. They should keep the questions simple and limit the total interview to no more than ten questions. With a shorter interview, the process will not be rushed and the interviewee will have time to think before answering. Also, the responses lead to other unplanned questions that the interviewer may have, thus making it a more natural process.

When the group has completed its list, each member should note the questions so everyone has a copy. Give Trainees twenty minutes to complete this exercise.

Suggested categories for the group developing questions for mothers:

- Community assets from a mother's point of view
- Health beliefs, practices, and problems
- Diet and child feeding habits

- Food: sources, preparation, and storage
- Water and sanitation systems, beliefs, practices, and problems

Suggested categories for the group developing questions for health care workers. Please note that a "worker" may include a doctor or nurse in a hospital, a traditional birth attendant, a traditional healer, or someone working in a clinic. Depending on who is being interviewed, Trainees should form their questions accordingly. Categories can include:

- Community assets from a health worker's point of view
- Diseases or health problems they encounter and how they treat them
- Factors affecting or causes of these problems from the health worker's point of view
- Clinic policies/management issues

Suggested categories for the group developing questions for a community leader, e.g., a local government official, a district officer, or an informal leader in the community. Depending on who they are interviewing, Trainees may need to adjust their questions. Categories can be:

- Assets or resources available to the community
- Major health needs/problems in the community
- Causes or factors affecting these problems
- What is being done about these problems

STEP 4. Ask the Trainees to reconvene and have each group present its list of questions. Ask the other participants if they would like to add any questions. (Members of the group can add their copy of the list.) Each member of each group will now have a questionnaire to be used during their interview.

STEP 5. If you are not meeting with Trainees again before they carry out their interviews, complete steps 1-5 from the session **Interview Exercise**, p. 169, at this time.

RESOURCE

Gender and Development Training Manual, Booklet 4

SESSION PLAN

PART FOUR–SESSION 6.3:
INTERVIEW EXERCISE

OVERVIEW

In this session Trainees conduct one interview with a mother, health care worker, or community leader.

OBJECTIVES

By the end of this session the Trainees will be able to:

1. Conduct an interview in the community.
2. Gather additional health data through interviews.

TIME

2 hours

PREPARATION

If you are not going to meet with the Trainees before they do their interviews, do the following steps at the end of the session **Developing Interview Questions**, p. 166.

If possible, ask Trainees and/or Training staff to identify the people who will be interviewed and brief them in advance about the exercise.

In the case of Trainees interviewing health care workers and community leaders, staff should meet with these individuals in advance and set up an appointment for the Trainees to meet with the workers and leaders and interview them.

DELIVERY

STEP 1. Assign the Trainees to interview a mother, health care worker, or community leader, depending on which group they were in while developing the interview questions.

STEP 2. Those Trainees interviewing mothers may find it easiest to interview the mother of the family in which they are staying. If they are not staying with a host family, they may interview a mother at a local clinic or someone else identified by the Trainee or training staff.

STEP 3. Remind the Trainees about culturally appropriate ways to introduce themselves to the interviewees and ask them if they have any questions about how they should conduct their interviews.

STEP 4. If necessary, assign a language instructor, counterpart, or an English-speaking member of a host family to assist each Trainee with their interview. The Trainees themselves should try to ask as many of the interview questions as they can in the local language, but they may need help, especially with understanding the responses to their questions. If their language skills are limited, then the HCN can ask the questions. Remember that the main purpose of this exercise is to gather information.

STEP 5. If appropriate, give Trainees a time frame for completing their interviews; two hours should be more than adequate.

RESOURCE

Promoting Powerful People: A Process for Change, *Informal Interview Checklist*

192

SESSION PLAN

PART FOUR–SESSION 6.4:
PROCESSING THE INTERVIEWS

OVERVIEW

In this session the Trainees process the information they gathered in the interview exercise. They compare their own and HCN perceptions of community assets, child health needs/problems, and contributing factors, and add any new information to the lists they began in Session One, **Framework for Community Analysis**.

OBJECTIVE

By the end of the session the Trainees will be able to discuss the data they gathered during their interview and its implications for child health work.

TIME

30–45 minutes

STAFF

If one or more HCNs accompanied the Trainees on their interviews, invite them to participate in this session. They can help the Trainees interpret the answers to the interview questions, help in pointing out differences in communication styles, and perhaps add additional relevant cultural information.

DELIVERY

STEP 1. Explain the purpose of the session.

STEP 2. Ask the Trainees to describe what was easy and what was difficult about doing interviews. Have them describe what they would do differently in the future and why. Ask them if there was anything new or surprising about their experiences.

STEP 3. Divide the Trainees into the same groups they were in while developing the interview questionnaire (mothers, health workers, and community leaders). Ask each group to take the information they gathered in the interviews and, where appropriate, break it down into assets, health needs/problems, and factors creating or contributing to these needs and problems. Ask each group to identify a facilitator to write its information on three separate flip charts using the above categories. Ask the HCNs to join the groups and assist them in processing the information.

STEP 4. Bring the groups back together and have the facilitator from each group read their lists. Encourage the Trainees to keep notes on information on assets, needs/problems, and contributing factors.

STEP 5. Ask the Trainees if they noticed any differences between their perceptions and those of the people they interviewed. Discuss these differences. Ask the Trainees what they think accounts for these differences and what is their significance to the work of the Volunteer. Ask the HCNs to contribute to this discussion.

STEP 6. Ask the HCNs to give their comments on how the interviews went and, in particular, to point out any misunderstandings or misinterpretations that the Trainees may have had due to differences in communication styles (see the session **Developing an Interview Tool,** p. 166).

STEP 7. Remind the Trainees that as Volunteers they would be doing interviews with a counterpart or someone from the community. Ask the Trainees with whom in the community they might do this activity and how they would get that person involved.

SESSION PLAN

PART FOUR–SESSION 7.1:
TIME LINE OF DAILY ACTIVITIES

OVERVIEW

In this session the Trainees spend a day (or two half days) with a mother or health worker in order to gather information on their daily activities. The purpose of doing this is to understand the tasks and duties of mothers and health care workers during a typical day—how much time is spent on which activities during what part of the day. This information will help Trainees in planning interventions which are appropriate and timely (i.e., if a mother is busy collecting firewood or water in the morning, one would not schedule a health talk at that time; if a health care worker has difficulty with clinic/work/time management, then a Trainee might address this need in a future intervention). This session tends to be a real eye-opener for the Trainees, especially if careful attention is given to the selection of mothers with regard to socio-economic status. Trainees are usually placed in middle or upper income host families during their homestays, so visiting a mother from a lower income family shows them another side of life in the community.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain the time line concept and its value to them.
2. Gather additional data from mothers/health workers.

TIME

1 day

MATERIALS

Handout: *Time Line of Daily Activities*

PREPARATION

Prior to this session meet with the mothers and the supervisor(s) of the health care workers who will be involved in this exercise and explain that one or two Trainees would like to spend a day (or two half days) with them in order to gather information on their daily activities. Tell them that the purpose of doing this is to help the Trainees understand their tasks and duties during a typical day.

In some cultures, it is appropriate to bring a gift for the mother or children in the family when paying a visit. If this is the case in this culture, prepare the Trainees to do this. The same may be appropriate when visiting the health care workers.

DELIVERY

STEP 1. Explain the purpose of this session to the Trainees and ask them to divide into pairs. If you have a large group of Trainees, divide them into small groups. Ideally, there should only be a few Trainees in each group as too many Trainees following one mother or health care worker can be disruptive.

STEP 2. Ask half of them to spend a day with a mother. The assignment is to follow the mother through her day observing and recording (and/or assisting with) all her chores and activities. Start the day when the mother starts her day or as close as possible.

This exercise may be done with or without a language trainer or counterpart. Ask the Trainees to record all of the mother's activities on the handout, the time of day each activity took place, and how much time it took to do each activity. They should not limit themselves to the handout, but should ask questions as well.

STEP 3. Ask the other group to spend a day with a health care worker (this can be a doctor, nurse, TBA, or the equivalent). This exercise can be done with or without a language trainer or counterpart. The assignment is to follow the health care worker through his/her day observing all his/her activities. The Trainees should record the activities, the time of day each activity took place, and how much time it took to do each activity. They should ask the health care worker questions.

STEP 4. Ask the Trainees to record this information either on the handout *Time Line of Daily Activities* or in their notebooks.

RESOURCE

Gender and Development Training Manual, Booklet 5.

TRAINEE HANDOUT
PAGE 1 OF 2

TIME LINE OF DAILY ACTIVITIES

Person (Mother, etc.)	Activity	Time of day	How long it took	Issues/questions raised	Response
				197	

TRAINEE HANDOUT
PAGE 2 OF 2

TIME LINE OF DAILY ACTIVITIES

Person (Mother, etc.)	Activity	Time of day	How long it took	Issues/questions raised	Response

SESSION PLAN

PART FOUR–SESSION 7.2: PROCESSING THE TIME LINE EXERCISE

OVERVIEW

In this session the Trainees process the information they gathered in the session **Time Line of Daily Activities**, p. 173. They will discuss their findings and begin looking at possible consequences or applications of these findings when they are working with a community to develop interventions. The Trainees will also briefly discuss any new assets, child health needs/problems, and factors affecting these needs/problems from the mothers' and health care workers' points of view and add these to their lists.

OBJECTIVE

By the end of the session the Trainees will be able to discuss the results of the data they gathered during the time line observations, and discuss the implications of this data for child health work.

TIME

20–30 minutes

STAFF

Invite the language trainers and/or other host country national staff to participate in this session and ask them to give their input and perspective as the Trainees process their experiences.

DELIVERY

STEP 1. Explain the purpose of this session to the Trainees.

STEP 2. Process the Time Line/Daily Activities exercise with the entire group of Trainees. Begin with the Trainees who spent a day with a mother. Ask them what they learned from the exercise? What issues or questions came to mind when they were doing this exercise? Did they discuss these issues with the mother? If so, what did the mothers say? Discuss these findings.

STEP 3. Ask the Trainees if they see any possible consequences or applications of these findings when they are working with a community or mothers in a community to develop interventions. For example: if the Trainees see or discover that mothers are busy in the mornings collecting firewood or water or going to the market, they would not schedule a health talk at that time.

STEP 4. Ask the same questions of the Trainees who spent a day with a health care worker and discuss their findings. Do they see any possible consequences or applications of these findings when they are working with a community or health care workers to develop interventions. For example, if a health care worker has difficulty with clinic/work/time management because of patient load or no supervision, then a Volunteer might address this need or problem in a future intervention.

STEP 5. Ask the Trainees if they discovered any *new* assets, needs/problems, and factors affecting these needs/problems from the mothers' and health care workers' points of view.

STEP 6. Remind the Trainees that as Volunteers they would be conducting this activity with a counterpart or someone from the community. Ask the Trainees with whom in the community might they do this activity and how would they get them involved.

SESSION PLAN

PART FOUR–SESSION 8.1:

CONDUCTING A CHILD HEALTH ASSESSMENT

OVERVIEW

In this session the Trainees conduct several child health assessments in a clinic using the assessment tool from the session **Assessing the Sick Child**: Case Studies, p. 65 (Trainee handout *Management of the Sick Child Age Two Months Up to Five Years).* The purpose of this exercise is to give the Trainees practice in using the tool in communicating with mothers, and in gathering further information about child health issues in the community.

OBJECTIVES

By the end of this session the Trainees will be able to:

1. Explain how to conduct a health assessment.
2. Conduct child health assessments.
3. Gather additional child health data.

TIME

4 hours

PREPARATION

Please Note: Part Two, Session 4 teaches the Trainees how to conduct child health assessments using the Integrated Management of Childhood Illnesses (IMCI) approach. It is essential that you do this session prior to this exercise.

Also, prior to this session, identify a clinic where the Trainees can conduct their assessments. If possible, select a clinic that is using the IMCI approach developed by WHO and where the clinic workers have been trained in using the IMCI form. Meet with the clinic supervisor to set up the activity and to prepare the clinic workers for the Trainees' visit. It is important that the Trainees have an opportunity to assess children between the ages of 2 months and 5 years who are sick. If possible, have each team work with a clinic health worker.

Tell the Trainees to review the booklet ***Assess and Classify the Sick Child Age Two Months Up to Five Years*** and bring it with them to class.

DELIVERY

STEP 1. Explain the purpose of this session to Trainees. Explain that they will be conducting child health assessments on 4–6 children in a clinic. Ask them to pair up. Give them the time and day of these visits.

STEP 2. Give each team 4–6 blank recording forms and explain that one Trainee will ask the questions and make the observations and the other will fill in the answers on the form. With the next mother/child, they should switch these roles so that they each get a chance to practice asking the questions. Hopefully, each Trainee will do a minimum of two assessments. If their language skills are not adequate for this exercise, arrange for a translator to accompany them. If the clinic health workers speak English, then they may act as translators.

STEP 3. Tell the Trainees that they will be practicing the following skills:

- Asking the mother about the child's problem
- Checking for general danger signs
- Asking the mother about the four main symptoms:
  - cough or difficulty breathing
  - diarrhea
  - fever
  - ear problem
- When a main symptom is present:
  - assessing the child further for signs related to the main symptom
  - classifying the illness according to the signs which are present or absent
- Checking for signs of malnutrition and anemia and classifying the child's nutritional status
- Checking the child's immunization status and deciding if the child needs any immunizations today
- Assessing any other problems

STEP 4. Go over the steps for asking the mother what the child's problems are in chapter 1 of the booklet ***Assess and Classify the Sick Child Age Two Months Up to Five Years***, p. 3–4. Give particular attention to good communication skills (p. 4).

STEP 5. After the Trainees complete their assessments, they should meet with the clinic health workers and the clinic supervisor to discuss their findings, so that the children who are ill get appropriate treatment and follow-up care.

STEP 6. Clarify any questions or comments they may have about using the form and carrying out this exercise.

STEP 7. Tell the Trainees that in the next session they will process their experiences and each one will do a case presentation on one sick child to the group. They should prepare in advance for their presentations and should use the following format:

1. Communication with the mother (what was easy or difficult about it).
2. Present the case by going through the form, systematically answering all the questions, and giving any observations they made according to the form.
3. Summarize the case by giving the classification(s) of illness this child had, giving the child's immunization status, and recommendations for future immunizations.
4. Discuss their experience working with the clinic staff.
5. Ask the group how they felt in general about their experiences.

SESSION PLAN

PART FOUR–SESSION 8.2:
CASE PRESENTATIONS
(PROCESSING THE CHILD HEALTH ASSESSMENT EXERCISE)

OVERVIEW

In this session the Trainees process their experiences in conducting child health assessments in the clinic. The areas for discussion should include communication with the mother, using the form, illnesses they encountered, and working with the clinic staff. Trainees also have the opportunity to give a case presentation on a sick child.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss the information they gathered during their child health assessments, and their experience with using the IMCI form.
2. Share and process their experiences talking with mothers and clinic staff.

TIME

1 hour (depending on size of group)

STAFF

Invite the language trainers and/or other host country national staff to participate in this session and ask them to give their input and perspective as the Trainees process their experiences.

DELIVERY

STEP 1. Explain to the Trainees that each one will be doing a case presentation on one sick child whom they assessed during their visit to the clinic. If it is a large group and time is a limiting factor, ask the Trainees to break up into two to three groups to give their presentations. Tell them they have 5 to 10 minutes for each presentation. Limit the questions and discussion among the group during the case presentations. This can be done at the end.

STEP 2. Ask each Trainee to give a case presentation using the following format:

1. Communication with the mother (what was easy or difficult about it).
2. Present the case by going through the form systematically, answering all the questions, and giving any observations they made according to the form.
3. Summarize the case by giving the classification(s) of illness the child had, giving the child's immunization status and recommendations for future immunizations.
4. Discuss their experience in working with the clinic staff.
5. Tell the group how they felt in general about their experiences.

STEP 3. During the presentations, take notes about each case and the Trainees experiences. At the end of the presentations, discuss similarities and differences about the cases and the Trainees' experiences. Trainees can ask their questions at this time.

STEP 4. Ask the Trainees what was easy or difficult about using the form. What did they learn by talking with mothers and clinic workers? What would have improved these encounters?

STEP 5. Ask the Trainees if they have anything they want to add to their lists of assets, problems, and contributing factors and, if so, have them do it at this time.

SESSION PLAN

PART FOUR–SESSION 9.1:

LOOKING AT CHILD HEALTH RECORDS

OVERVIEW

Gathering information from child health records in the clinic will provide data on the health conditions that are prevalent in the community. If it is not feasible to access individual child records, then have the Trainees review child growth/immunization records which each mother should have. This may be done in the clinic when mothers come with their children.

Please Note: This session as described below, may be very difficult to conduct in some countries. If obtaining access to health records at a clinic is not possible, redesign this session to be done with model records instead of actual records. It is important for Trainees to have the opportunity to practice examining child health records, whether this is done in a clinic with actual records (ideally) or with model records.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss the system of child health records.
2. Examine child health records.

TIME

2.5 hours

MATERIALS

Handouts:

- *Gathering Information from Child Health Records*
- *Gathering Information from the Child Growth/Immmunization Records*

206

PREPARATION

Prior to this session visit the clinic and meet with the person in charge to explain that you would like Trainees to review records kept on children between 2 months up to 5 years old or the child growth/ immunization records in order to gather information on childhood diseases that are prevalent in this community. Explain that this information will be used to develop interventions, such as health talks with mothers, and will *not* be used to critique treatment given by their staff. You should also show the person in charge a copy of the information gathering form that the Trainees will be using and explain that the names of the children will not be used on the form.

DELIVERY

STEP 1. Tell the Trainees that they will be gathering information from child health records at the clinic or from the mothers who come to the clinic. Give them the appropriate handout—either the *Gathering Information from Child Health Records or the Gathering Information from the Child Growth/ Immunization Records.* As each clinic may have its own specific type of child health record, show the Trainees an example of the type of records they will be reviewing and go over the information they will be looking for. Explain to the Trainees that they should not write down the name of the child in order to preserve medical confidentiality.

STEP 2. Tell the Trainees that they will be looking for and noting all or some of the following information:

- Age of child
- Weight
- Primary problem or reason why this child was brought to the clinic; other problems or symptoms presented
- Treatment given
- Immunizations given
- Health education or preventive measures

STEP 3. Tell the Trainees that they may not get all of this information, but should gather what they can. Each Trainee should review 10–20 records, depending on the time they have and the availability of records. Give them two hours to complete this exercise.

STEP 4. Ask two to three Trainees to collect the forms from the remaining Trainees and have them collate the data on flip charts. In the next session have one of the Trainees present the data to the group.

TRAINEE HANDOUT
PAGE 1 OF 2

GATHERING INFORMATION FROM CHILD HEALTH RECORDS

Age of Child	Weight	Primary Problem	Other Problems	Treatment	Immunizations	Health Education

GATHERING INFORMATION FROM CHILD HEALTH RECORDS

Age of Child	Weight	Primary Problem	Other Problems	Treatment	Immunizations	Health Education

TRAINEE HANDOUT
PAGE 1 OF 2

GATHERING INFORMATION FROM CHILD GROWTH/IMMUNIZATION RECORDS

Age of Child	Weight	Immunizations

GATHERING INFORMATION FROM CHILD GROWTH/IMMUNIZATION RECORDS

Age of Child	Weight	Immunizations

SESSION PLAN

PART FOUR–SESSION 9.2:

PROCESSING INFORMATION GATHERED FROM CHILD HEALTH RECORDS

OVERVIEW

In this session the Trainees look at the data they collected from the clinic records and discuss the health conditions that are prevalent in the community.

OBJECTIVE

By the end of the session the Trainees will be able to discuss the results of their examinations of child health records and the implications of the data they have gathered.

TIME

30 minutes

STAFF

Invite the language trainers and/or other host country national staff to participate in this session and ask them to give their input and perspective as the Trainees process their experiences.

DELIVERY

STEP 1. Explain the purpose of the session.

STEP 2. Ask one of the Trainees to present the data that was gathered from the clinic records or the child growth/immunization records (whichever one was used).

STEP 3. Discuss their findings using the appropriate questions listed below as a guide.

- What was the average age and weight of the children? What were the primary problems or diagnosis presented?
- Were any other problems recorded?
- What treatments were given? Did they seem appropriate?
- What was the availability of supplies/medicines/etc.?
- Were immunizations recorded? If a child was not up-to-date on their immunizations, were they given the appropriate ones at this time or told to come back?
- Was any health education given and recorded in the record? Did it seem appropriate?
- Did they see any other types of forms and records that the clinic keeps on mothers and children? If so, what kind of information was collected?

STEP 4. Ask the Trainees to look at their problem/needs list from their child health notebooks and compare it with the data that they have just collected. Have them add any new information. Then, discuss any trends in health problems they see.

STEP 5. Remind the Trainees that as Volunteers they would be collecting data from the child health records with a counterpart or someone from the clinic or community. Ask the Trainees who they might do this activity with and how would they get them involved.

PART FIVE: ADDRESSING CHILD HEALTH ISSUES

INTRODUCTION

In the previous parts of this manual, Trainees have developed their knowledge of child health (Parts One and Two), learned how to enter and work with a community (Part Three), and learned how to gather child health information (Part Four). In this part Trainees will be asked to apply the skills and knowledge they have developed to design an actual child health intervention. The entire design process, as presented here, involves several steps:

1. Identifying key health problems.
2. Identifying causes.
3. Identifying solutions.
4. Designing an intervention.
5. Designing a monitoring and evaluation system.

In addition, this section also presents the fundamentals of behavior change and a series of exercises on preparing and delivering good health presentations. Health presentations are, of course, one of the most common kinds of interventions, which is why this manual covers them in such detail. They are also quite suitable for developing and delivering as part of PST. Other common interventions include mass media campaigns, one-on-one counseling are introduced in the session **Selecting an Intervention**, p. 244.

In the first four parts of this manual, it was possible for Trainees to actually carry out the various activities that were presented. In this section, however, while Trainees can go through all the steps of designing an intervention, including designing a monitoring/evaluation system, they may not be able to execute the actual intervention, unless it is something quite simple, such as a health talk. Trainees should not feel pressure to design only those interventions they could actually implement as part of PST. That would be extremely limiting and could easily jeopardize the essential integrity of the design process. That is, an intervention should be the natural outgrowth of correctly identifying a health problem, its cause, and its solution. Trainees should follow that process wherever it leads, whether or not the resulting intervention can be done as part of PST. There are two sessions included in this section, **Analyzing the Data with the Community** and **Designing an Intervention with the Community**, in which the Trainees have an opportunity to apply their knowledge and skills in a real life setting.

SUMMARY OF SESSIONS

SESSIONS 1.1–1.2:	**What is an Accomplishment? and Whose Activity Is It?** are sessions that help Trainees define accomplishment in the context of community development work and get them accustomed to thinking how to work with and through community members instead of doing all the work themselves.
SESSION 2:	**Problems or Causes** shows Trainees how to distinguish between a genuine health problem (e.g., malaria) and its cause (standing water, lack of window screens). Health activities usually address the latter, and Trainees need to understand the relationship.
SESSIONS 3.1–3.3:	**Analyzing the Data and Processing with the Community** ask Trainees to review the data they gathered in **Part Four: Understanding the Setting** and identify significant health problems. During the second session Trainees meet with the community to identify health problems from the community's perspective, and the third gives the Trainees an opportunity to process their findings from the meeting.
SESSION 4:	**Immediate and Ultimate Causes of a Health Problem** helps Trainees identify and distinguish between the two types of causes, immediate and ultimate in order to target interventions more accurately.

SESSIONS 5.1–5.3:	**The Process of Behavior Change, Factors Affecting Behavior Change, and Evaluating Target Behaviors** help Trainees understand the behavior change cycle, what affects behavior change, both positively and negatively, and examines behavior change in the context of the most common child health problems.
SESSIONS 6–9:	**Identifying Solutions, Selecting an Intervention, and Designing an Intervention 1 & 2** teach Trainees to identify possible solutions, to select an intervention (a means of implementing or putting the solution into practice), and design the intervention step by step, making use of whatever assets are available in the community.
SESSIONS 10.1–10.2:	**Designing an Intervention with the Community** gives the Trainees an opportunity to apply in a community setting what they learned and practiced in the previous sessions designing a small intervention which they can carry out with the community during PST. The second session processes the Trainees' experience of meeting with the community and sets up a time in which to plan and carry out the intervention.
SESSIONS 11.1–11.4:	**Establishing Baseline Data, Monitoring an Intervention, Making Adjustments, and Evaluating an Intervention** cover the basics of setting up and carrying out a monitoring and evaluation plan for an intervention.
SESSIONS 12.1-12.5:	**Quiz for Presenters, Training Adults, The Great Myth of Training, Presentational Voice, and Designing and Delivering a Health Talk** cover the basics of adult education, focusing on how to design and deliver a health education talk.

RESOURCE

Promoting Powerful People: A Process for Change, Section II describes additional interventions that can be carried out with the community.

SESSION PLAN

PART FIVE–SESSION 1.1:

STARTING WITH THE RIGHT PERSPECTIVE: WHAT IS AN ACCOMPLISHMENT?

OVERVIEW

Americans tend to define accomplishments as fairly significant results achieved after a considerable amount of effort. Such things are accomplishments, but in the context of doing development work as a Volunteer, accomplishments defined this way are not common occurrences. Volunteers need to understand that lesser, more modest activities can also be accomplishments—that is, they can have a lasting impact on people. This activity helps Trainees broaden their definition of accomplishments by showing examples of some of these lesser, but by no means insignificant, actions that can make a difference in people's lives.

OBJECTIVE

By the end of the session the Trainees will be able to discuss the idea that an accomplishment need not be the result of a complicated, time-consuming activity in order to have a lasting impact on the community.

TIME

20 minutes

MATERIAL

Handout: *What is an Accomplishment?*

DELIVERY

STEP 1. Explain the purpose of this session as a chance to determine what accomplishments in child health might mean.

STEP 2. Distribute the handout and ask the Trainees to read through each set of statements on their own and select the statement that they would consider to be the *least* significant accomplishment.

STEP 3. Review the exercise with everyone, soliciting their answers, which should be as follows:

1. Introducing two people who have not met before...
2. Joining a soccer club.
3. Teaching one mother about weaning foods.
4. Bringing a host country friend along when you ...
5. Spending a day with your host mother.
6. Putting up screens on your window.

STEP 4. Ask Trainees how they define accomplishment? To what extent can their least significant activities be considered accomplishments? They can still have a lasting impact on people. Ask Trainees how these lesser, but by no means insignificant actions, can make a difference in people's lives. How might they contribute to improving health practices? (If time permits, have small groups each discuss one situation and then report out.) Possible answers:

1. Introducing two people who end up working together. In this situation, the Volunteer is acting as a catalyst in getting community members working together; they become interdependent on each other, rather than dependent on the Volunteer or outsiders for help.
2. Joining a soccer club may be a way to meet people in the community, to network and become more involved in the community. This will give you credibility and they will learn to trust you as a friend.
3. Teaching one mother about weaning foods may seem like a minor accomplishment because it is only *one* person, but remember that this mother has relatives and friends that she can influence. She will be able to help change the behavior and thinking of her relatives and peers much better than you, as an outsider, could. In this way, one person can bring about widespread and long-lasting change in a community.

4. Bringing a host country friend along when you do a survey addresses a fundamental principle of community development—getting local people to help in a project or activity rather than doing it yourself. It is important to teach others how to do something so that when you leave they have the skills and knowledge to continue.

5. Spending a day with a host mother may seem like a waste of time and energy, accomplishing very little. But during that day you will be able to make observations, ask questions and add to your knowledge about local conditions, what people think and believe in, what a mother or a community wants and needs, etc. You can use this knowledge to ensure that whatever project you undertake or become involved in will succeed. There are many examples of projects that failed because of lack of understanding or knowledge of the local conditions, beliefs, and practices.

6. Putting up screens on your windows may seem to be an unimportant and minor accomplishment as far as your work goes, but remember that teaching others indirectly by example sometimes is more effective than directly teaching or talking to others.

STEP 6. Ask Trainees to summarize some ways small accomplishments might occur that can be significant and change people's lives. Some possible answers:

1. Helping people work with others.
2. Developing skills in community members.
3. Developing people's trust in Volunteers.
4. Modeling behavior others then mimic.

TRAINEE HANDOUT

WHAT IS AN ACCOMPLISHMENT?

Below you will find six sets of statements. For each set (of three) check the one statement which in your opinion describes the **least important** or significant accomplishment.

1. ___ Introducing two people who have not met each other before who end up working together.
___ Finding funding for a small project.
___ Fixing a broken microscope in a clinic so the local doctor can diagnose stool exams properly.

2. ___ Teaching your counterpart how to make a good visual aid for his or her health talk.
___ Joining a soccer club.
___ Discovering the source of contamination at the local well.

3. ___ Meeting with the community leaders to discuss a health project.
___ Organizing an immunization campaign with the local health worker.
___ Teaching one mother about weaning foods.

4. ___ Bringing a host country friend along when you do a survey.
___ Teaching a nurse-midwife to give a health talk on breast-feeding to a mothers club.
___ Completing a health survey and presenting the findings to the health committee.

5. ___ Teaching a counterpart to give a health talk.
___ Helping a mother put up window screens.
___ Spending a day with your host mother.

6. ___ Convincing a group of mothers to give rehydration solution when their children have diarrhea.
___ Going to the capital and bringing back rehydration packets for the clinic.
___ Putting up screens on your windows.

SESSION PLAN

PART FIVE–SESSION 1.2:

STARTING WITH THE RIGHT PERSPECTIVE: WHOSE ACTIVITY IS IT?

OVERVIEW

This session helps Trainees begin thinking of their role as a Volunteer in the context of working with the community and in particular with counterparts. They need to understand that their primary "job" is to get things done through other people and not to do everything (or even most things) themselves: it is to help others learn how to help themselves.

OBJECTIVE

By the end of the session the Trainees will be able to discuss the concept of building self-sufficiency.

TIME

10–15 minutes

MATERIAL

Handout: *Starting with the Right Perspective: Whose Activity is It?*

DELIVERY

STEP 1. Introduce the session by saying that they will be exploring the role they will play as a Volunteer. Ask them to read directions and answer questions if needed.

STEP 2. Distribute the handout. Ask Trainees to complete the exercise individually.

STEP 3. Review the exercise, soliciting their answers and reasons for their choices.

STEP 4. It is important to make the point that the statements in the exercise are not presented within a situational context. Depending on the situation, it will sometimes be better—even necessary—to take action yourself rather than working through a HCN. The idea is not to *never* do anything on your own, but to always consider the option of doing it with or through someone else so that you are building skills in others who will remain after you leave.

ANSWERS: The correct choice in each pair is as follows:

1b, 2b, 3a, 4b, 5b, 6a, 7b, 8a, 9b

TRAINEE HANDOUT

STARTING WITH THE RIGHT PERSPECTIVE: WHOSE ACTIVITY IS IT?

Community development workers, such as child health Volunteers, should view their primary task as helping others get things done, and not merely doing things themselves.

Read the pairs of statements below. Check the statement in each pair that you think reflects the role of a Volunteer in community development.

1a. ____ We need to start a nutrition program.
1b. ____ We need to see if anyone wants to start a nutrition program.

2a. ____ I should talk to the village chief about this.
2b. ____ Can you come with me to see the village chief about this?

3a. ____ What do you think the next step is?
3b. ____ Let's call a meeting for next Wednesday.

4a. ____ I know a woman who can help us with this.
4b. ____ Do you know anybody who would be able to help us with this?

5a. ____ I think we should....
5b. ____ What do you think we should...?

6a. ____ Do you know anyone who can...?
6b. ____ I can....

7a. ____ This is a great idea.
7b. ____ What do you think of that idea?

8a. ____ Do you think this is a problem?
8b. ____ We could fix this problem by....

9a. ____ We need to....
9b. ____ What do we need to do now?

SESSION PLAN

PART FIVE–SESSION 2:
PROBLEMS OR CAUSE?

OVERVIEW

This session begins a series of sessions focusing on identifying and addressing key health problems in a community. As a first step, Volunteers must be able to distinguish between a genuine health problem, usually a disease or health condition, and the causes of such diseases or conditions.

OBJECTIVE

By the end of the session the Trainees will be able to:

1. Explain the difference between a health problem and a cause.
2. Distinguish health problems from causes.

TIME

10–15 minutes

MATERIAL

Handout: *Problems or Causes?*

DELIVERY

STEP 1. Ask Trainees to give an example of a health problem and a cause of that problem. Lead a brief discussion about why it is important not to confuse a problem with its cause.

STEP 2. Distribute the handout and introduce the exercise. Have Trainees do the exercise.

228

STEP 3. Go over the answers (below). Note that in a few cases a problem can also be the cause of another problem. Diarrhea, a problem, can also be a cause of malnutrition. Similarly, measles or a respiratory infection (both problems) may be a cause of diarrhea. If Trainees do not bring this up as they discuss the worksheet, after you've gone over the answers, ask them to identify which problems can also serve as the cause of other problems.

STEP 4. Return to your opening discussion about confusing problems and causes. Ask a Trainee to summarize the learning about this.

ANSWERS:

1. C 2. P 3. C 4. C 5. C 6. P 7. C 8. C
9. P 10. C 11. C 12. C 13. P 14. C 15. P

TRAINEE HANDOUT

PROBLEMS OR CAUSES?

In the earlier part of your training, you have been gathering information about your community, including information on its health problems. In this exercise, you will begin to analyze those problems more closely, the first step in designing any kind of community health effort or intervention.

When you are analyzing health problems, it's important to be able to distinguish an actual problem from its cause. Mosquitoes, for example, are not a health problem; they are, rather, the cause of malaria, which is the real problem. Read the following list and put a **C** next to anything that is the cause of a health problem and a **P** next to the actual health problems.

1. ____ No screens on windows
2. ____ Respiratory infection
3. ____ Lack of vitamin A in the local diet
4. ____ Lack of household ventilation
5. ____ Contaminated water
6. ____ Intestinal worms
7. ____ Inadequate breast-feeding
8. ____ Lack of vaccines at the health clinic
9. ____ Malaria
10. ____ No doctor in the village
11. ____ People can't afford mosquito repellent
12. ____ People coughing
13. ____ Malnutrition
14. ____ Flies landing on food
15. ____ Measles

SESSION PLAN

PART FIVE–SESSION 3.1:
ANALYZING THE DATA

OVERVIEW

After Trainees have done their information/data gathering and learned to distinguish between problems and causes (the previous session), the next step is to begin identifying key health problems in the community. These may be the problems that Volunteers and their communities will want to address in their health intervention efforts.

This session takes the Trainees through the process of analyzing the data for themselves and prepares them for the following session which has the Trainees analyze the data with the community.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Identify key health problems in the community.
2. Discuss health problems from the community's and the Peace Corps project's perspectives.

TIME

20–30 minutes

MATERIAL

Handout: *Analyzing the Data*

Flip chart paper and markers

PREPARATION

The Trainees must have done some of the data gathering sessions in Part IV prior to this session. In preparation for this session, ask the Trainees to read through their country's health project plan. Ask them to bring a copy of the project plan along with their child health notebooks to this session.

DELIVERY

STEP 1. Introduce the activity using the overview above.

STEP 2. Distribute the handout. Have Trainees look through their child health notebooks and identify the health problems (major or minor) which they have recorded there.

STEP 3. Ask Trainees to call out their items and make a list on a flip chart. Ask them to look at the final list and eliminate anything that is a cause rather than a problem.

STEP 4. Ask Trainees how they would distinguish between a major problem and a minor problem. The distinction should include:

- The problem must be widespread or common.
- The problem must be serious.

Ask them to look at the list again and pare it down to "major" problems. Note that while a community may have many health problems, generally health interventions focus on the most important ones.

STEP 5. Ask the Trainees to think back to when they were gathering information from the community. In their discussions or interviews with their host family members, neighbors, community leaders, health workers, or host agency staff, did they ever hear a different perspective than theirs as to what health problems existed in the community? What were some of the things the community mentioned? Ask the Trainees to take a second look at the list of "major" health problems and decide which ones are from the community's perspective. Write these under that column in their handout.

STEP 6. Note that the Peace Corps health project may have yet another view of what is and is not a problem. Ask Trainees to look at their project plan and decide which of the "major" health problems on the list are from the Peace Corps health project's point of view. Write these under that column in their handout.

STEP 7. Lead a discussion about why the lists of problems may be different. Suggest that any problem that ends up in all three columns might be an ideal target for a Volunteer's efforts. Ask them to identify any problems that appear on all lists. Finally, ask if there is agreement by all three perspectives, are there any reasons a particular problem would *not* be a good target for your efforts? Possible answers (part of a larger problem, not adequate resources to address it, not *really* considered a major problem by community, and so on.)

233

TRAINEE HANDOUT
PAGE 1 OF 3

ANALYZING THE DATA

(GATHERED IN "UNDERSTANDING THE SETTING")

Now that you have completed information gathering exercises in your community, you need to begin the process of focusing on major child health problems. These are potential targets of health activities you may undertake at your site. You have been recording such problems in your notebook for some time.

In this exercise, you should go through your notebook and make a list of all of the problems you have written down (not worrying, for the moment, about whether these are major or minor). Try not to list anything that is really a cause rather than a problem. You may have more (or less) than 12 problems on your list.

LIST OF HEALTH PROBLEMS

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________

TRAINEE HANDOUT
PAGE 2 OF 3

ANALYZING THE DATA

Pare the list down to "major" problems using the following criteria:

1. The problem must be widespread or common
2. The problem must be serious

You may have more (or less) than eight "major" problems on your list.

LIST OF "MAJOR" HEALTH PROBLEMS

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

The next step is to classify these problems according to the following three perspectives:

1. Is this a problem from your perspective?
2. Is this a problem from the community's perspective?
3. Is this a problem from the perspective of your Peace Corps health project?

TRAINEE HANDOUT
PAGE 3 OF 3

ANALYZING THE DATA

On the chart below, list the problem under the appropriate column(s).

Your perspective	The community's perspective	Peace Corps program perspective
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.

Now list any problem that appears in all three columns. These may be ideal targets for your efforts as a Volunteer.

KEY HEALTH PROBLEMS

1. ______________________________
2. ______________________________
3. ______________________________

236

SESSION PLAN

PART FIVE–SESSION 3.2:
ANALYZING THE DATA WITH THE COMMUNITY

OVERVIEW

After the Trainees have practiced analyzing the data from the information gathered, they now meet with the community and go through the problem analysis process with the community in order to identify what the community sees as key health problems.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Identify key health problems *with* the community.
2. Discuss health problems from the community's perspective.
3. Practice conducting/facilitating a meeting with the community.

TIME

1 hour

MATERIALS

Blackboard or flip chart paper

STAFF

Invite the APCD to attend and/or facilitate the meeting. (In some cultures, having a person such as the APCD present gives credibility and importance to the meeting in the eyes of the community.)

If the APCD is not available, invite one or several of the language staff to come to the meeting and act as translators, if needed.

237

PREPARATION

Prior to this session meet with the community leaders and explain the purpose of having a community meeting with the Trainees. Ask the community leaders for their input and advice and set a date, time, and place for the meeting that is convenient for them. Ask them to invite community members to the meeting. Check out the meeting place to see what the set-up is: What is the seating arrangement? Are there plenty of chairs available? Is there a blackboard and chalk (or flip chart) available and a table to use?

Prepare the Trainees for the meeting by explaining the purpose, the venue/date/time, who will be attending, who will be facilitating, and how the meeting will proceed (steps 1–9 below).

Select and prepare a facilitator for the meeting. This may be the APCD, the technical trainer, and/or one of the Trainees (if their language skills are adequate).

DELIVERY

STEP 1. Ask the spokesperson or community leader to introduce the meeting. Then introduce the APCD and/or facilitator, the Trainees, and any language staff present.

STEP 2. Ask the facilitator to conduct the meeting and carry out the remaining steps.

STEP 3. Begin by explaining that the Trainees have been living and working in this community as part of their training. Tell the community about the information gathering activities that they have done so far and what the purpose was.

STEP 4. Ask the community members to tell you what they think their child health problems are. You may need to call on the members or ask the spokesperson to call on the members to get their input. As the members (or spokesperson) mention a health problem, write it on the flip chart or blackboard. This should be done in the local language.

STEP 5. Continue asking for input until all the possible problems are listed. Remember that the role of a facilitator is to listen to everyone's ideas and not interject their own opinion. At this point in the process, the facilitator should write everything down that it is said.

STEP 6. Read the list out loud. Some of the "health problems" mentioned by the community may actually be *causes* of a problem rather than a real health problem. Ask the community what the difference is and why it is important to differentiate between a cause and a problem. Then read each item on the list and ask the community members if that item is a cause or a real health problem. Eliminate anything that is a cause rather than a problem.

STEP 7. You should now have a general list of health problems. Ask the community members to look at the list again and decide which ones are "major" health problems in their opinion. Ask them which problems are widespread or common and which ones they consider to be serious health problems.

STEP 8. If the community has more than one health problem, ask the members to prioritize the list. You may do this by asking the community members for a show of hands to select the #1 problem, the #2 problem, or use some other ranking technique.

STEP 9. Explain to the community members that in the next meeting they will discuss possible solutions to these major health problems and decide on feasible interventions that can be done to bring these solutions about.

RESOURCES

Gender and Development Training Manual, Booklets 5 and 6.
Promoting Powerful People, Section III, Session 2.

SESSION PLAN

PART FIVE–SESSION 3.3:

PROCESSING THE SESSION ON ANALYZING THE DATA WITH THE COMMUNITY

OVERVIEW

In order for the Trainees to learn from their experience of conducting and/or participating in a community meeting, it is important that they process the experience. They can discuss what seems important to the community, how community members express their health problems, and how these perceptions may be influenced by you or other "official" people at the meeting. It is also an opportunity to discuss how this meeting proceeded, and what more they need to learn about how meetings in a community are organized and conducted.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss their experience and findings from the meeting with the community.
2. Compare their perceptions of health problems with those of the community.

TIME

15–20 minutes

MATERIALS

Flip chart

STAFF

If the trainer is not familiar with the norms of organizing and conducting a community meeting in this culture, s/he may ask the APCD, the cross-cultural coordinator, and/or some of the language staff to assist with this session.

PREPARATION

Ask one of the Trainees to write on a flip chart the list of health problems generated with the community. If the list was generated in the local language, ask the Trainee to translate it into English on the flip chart.

If the community meeting was difficult in any way (for example, no one wanted to talk, one person dominated, and so on) you may need to rearrange this session, starting with steps 3 and 4. More time will probably be needed for the session.

DELIVERY

STEP 1. Explain the purpose of this session and tell the Trainees that in the next several sessions they will be looking at immediate and ultimate causes, discussing behavior change, and coming up with solutions and interventions. In this session they will only be processing the findings from the community meeting.

STEP 2. Ask the Trainees to look at the list of major health problems they generated on their own based on their information gathering. Have them compare their perceptions of the health problems and the community's perceptions of the health problems to the list of health problems generated during the meeting with the community. Discuss any differences they may find, speculating on why there are those differences.

STEP 3. Discuss the process of how the community meeting was organized and arranged—which community leader (or leaders) was approached, what was said, and how the meeting was called.

STEP 4. Discuss the dynamics of the meeting. Ask the Trainees what their observations of the meeting were and discuss these. Then ask the facilitator to describe their experience in facilitating the meeting—what worked, what didn't, what they would do differently, etc. Ask the APCD, cross-cultural coordinator and/or language instructors to answer any questions and explain the dynamics of the meeting from a cross-cultural point of view.

241

STEP 5. Summarize the session by going over the list of community perceptions and listing lessons learned. Ask the Trainees to make any notes in their child health notebooks that will be useful to them in the future.

RESOURCE

Gender and Development Training Manual, Booklet 6

SESSION PLAN

PART FIVE–SESSION 4:

CAUSES OF A HEALTH PROBLEM: IMMEDIATE AND ULTIMATE

OVERVIEW

After identifying major health problems in and with the community, the next step in any health intervention is to discover the causes of those problems. This session gets Trainees started on this process, making the important distinction between immediate and ultimate causes.

OBJECTIVE

By the end of the session the Trainees will be able to explain the concept of immediate and ultimate causes and distinguish between the two.

TIME

30–40 minutes

MATERIALS

Blackboard

Handout: *Causes of a Health Problem: Immediate and Ultimate*

PREPARATION

An alternate method for this lesson is to have trainees work in groups using the handout only.

DELIVERY

STEP 1. Introduce the session using the overview.

STEP 2. Distribute the handout and ask the trainees to read the definitions of immediate and ultimate causes. Discuss them and clarify with an example.

STEP 3. Have Trainees, in groups, try to come up with as many immediate and ultimate causes of malnutrition in the community as possible. Give them about ten minutes.

STEP 4. Solicit the results of the groups' discussions, recording them on a flip chart. Be sure not to list any immediate causes as ultimate, and vice versa. The Trainees may want to note information for later use.

STEP 5. Trainees should now repeat this activity (Steps 3 & 4) with the other major health problems they have identified in and with the community. Give each group one problem to work on and about 10 minutes to complete their list of causes. Then solicit and record the information.

STEP 6. Close by pointing out that we have now subjected each (or some) of the major child health problems in the community to a systematic analysis of their immediate and ultimate causes, a major step in the process of identifying and designing appropriate health care interventions. In most cases, you will be working on some causes of a problem, not all of them. It might be better to use the phrase "working toward solving" instead of "solving" a problem. Ask someone to summarize the importance of this activity.

TRAINEE HANDOUT
PAGE 1 OF 4

CAUSES OF A HEALTH PROBLEM: IMMEDIATE AND ULTIMATE

In previous exercises, you identified the major health problems in your community. The next step in the process of problem solving is to identify the causes of these problems. But it is important to first understand that most problems have two different types of causes, immediate and ultimate, and that you need to be aware of both. These two types of causes are defined as follows:

> **Immediate** – the direct or nearest (sometimes called proximate) cause of a problem, usually the result of an ultimate cause. For diarrhea, an immediate cause would be contaminated food.
>
> **Ultimate** – a more distant or fundamental cause of a problem, frequently the explanation behind an immediate cause. For diarrhea, an ultimate cause might be poor sanitation (which results in flies landing on feces and then contaminating exposed food). "Ultimate" does not necessarily mean a first cause, but rather a cause more removed and indirect than an immediate one.

In designing solutions for health problems, it is important to try to trace the causes of the problems back as far as possible, to keep asking the question "Why?" until you can no longer answer it. This does not mean that all solutions have to address ultimate causes, but you should at least be aware of ultimate causes before you start designing solutions.

Let's take the example of malnutrition. One of the immediate causes is poor diet. But what causes a poor diet? It could be the lack of certain foods. And why are certain foods lacking? Because the family can't afford them. And why can't the family afford them? Because these foods are not grown locally and have to be imported. And why aren't they grown locally? The soil may be bad. What's wrong with the soil? It needs fertilizer. In tracing a problem back to its roots, looking at the sources of immediate causes and then at the sources of those sources, you discover valuable information with important implications for choosing a solution.

TRAINEE HANDOUT
PAGE 2 OF 4

CAUSES OF A HEALTH PROBLEM: IMMEDIATE AND ULTIMATE

PART ONE:

Your task now is to continue to consider the immediate and ultimate causes of malnutrition in your community and to list these below. A few have been given to you.

IMMEDIATE CAUSE: Lack of breast-feeding

ULTIMATE CAUSES:
1. mother is malnourished herself
2. ____
3. ____
4. ____
5. ____
6. ____

IMMEDIATE CAUSE: Child has persistent diarrhea

ULTIMATE CAUSES:
1. ____
2. ____
3. ____

IMMEDIATE CAUSE: ____

ULTIMATE CAUSES:
1. ____
2. ____
3. ____

TRAINEE HANDOUT
PAGE 3 OF 4

CAUSES OF A HEALTH PROBLEM: IMMEDIATE AND ULTIMATE

PART TWO:

Now, as directed by your trainer, go through the same process for some of the other major problems you have on your list. Use the worksheet below to record your information.

CAUSES OF CHILD HEALTH PROBLEMS–WORKSHEET

MAJOR HEALTH PROBLEM: ______________________________

IMMEDIATE CAUSE: ______________________________

ULTIMATE CAUSES: 1. ______________________________

2. ______________________________

3. ______________________________

IMMEDIATE CAUSE: ______________________________

ULTIMATE CAUSES: 1. ______________________________

2. ______________________________

3. ______________________________

IMMEDIATE CAUSE: ______________________________

ULTIMATE CAUSES: 1. ______________________________

2. ______________________________

3. ______________________________

TRAINEE HANDOUT
PAGE 4 OF 4

CAUSES OF A HEALTH PROBLEM: IMMEDIATE AND ULTIMATE

MAJOR HEALTH PROBLEM: ____________________

IMMEDIATE CAUSE: ____________________

ULTIMATE CAUSES:
1. ____________________
2. ____________________
3. ____________________

IMMEDIATE CAUSE: ____________________

ULTIMATE CAUSES:
1. ____________________
2. ____________________
3. ____________________

IMMEDIATE CAUSE: ____________________

ULTIMATE CAUSES:
1. ____________________
2. ____________________
3. ____________________

Session Plan

Part Five–Session 5.1:

The Process of Behavior Change

Overview

In previous sessions, Trainees identified major health problems and their causes, both immediate and ultimate. The next step in the process is to devise solutions for the problems; in other words, actions that will eliminate one or more causes.

Solutions almost always involve getting people to change their behavior, either to start or stop doing something that is helpful/harmful to a child's health. To identify, evaluate, and implement solutions, Volunteers need to understand the key concepts of behavior change: the process, factors supporting behavior change, and factors preventing or hindering behavior change. The next three sessions address behavior change, beginning here with the process.

Objectives

By the end of the session the Trainees will be able to:

1. Explain the behavior change model and define the stages of the process.
2. Find examples of the behavior change model at work in their own lives.

Time

20–30 minutes

Materials

Handout: *The Process of Behavior Change*

DELIVERY

STEP 1. Introduce the session using the overview.

STEP 2. Distribute the handout and go over the explanation of the process. Ask for questions.

STEP 3. Ask the Trainees to work on their own. Ask each one to think about a behavior change that they might have gone through at some point in the past. Then answer the five questions at the end of the handout.

STEP 4. Solicit and record key words in the answers to each of the questions. For example,

1. How did you become aware of this behavior?
    - someone told me
    - read
    - television
    - saw someone do it
    - lecture
    - interact

Ask Trainees also record these lists as they will become very useful in the next session.

STEP 5. Conclude by pointing out that we now have five lists that will be very important when the time comes to design a health intervention:

- list of how people become aware of a behavior
- list of what causes people to become interested in a behavior
- list of what motivates people to try a behavior
- list of what motivates people to adopt a behavior
- list of what motivates people to keep up a behavior after they adopt it

TRAINEE HANDOUT

THE PROCESS OF BEHAVIOR CHANGE

The solutions to most health problems involve some kind of behavior change. In your work as a Volunteer, you will probably be getting the target group of people to do something that is helpful, or stop doing something that is harmful, to children's health. To identify and implement effective solutions, you will need to understand how behavior change takes place and what factors contribute to and hinder it.

In this exercise, you will begin by looking at the process of behavior change, the actual steps people go through in acquiring a new behavior. These five steps are listed below.

1. **AWARENESS:** People learn of the target behavior, either from other people or from the media. At this stage they are largely indifferent to the behavior and pay no particular attention, but they have at least been exposed to it. They know it exists.
2. **INTEREST and CONTEMPLATION:** People become curious about and take an interest in the target behavior. They ask about it or otherwise try to get more information. They consider whether to try the behavior and may reflect on its advantages and disadvantages.
3. **TRIAL and EVALUATION:** People try the target behavior and evaluate the effects and consequences. They see what doing it actually involves and what it leads to, and decide if the results are worth the time, effort, cost, and so on.
4. **ADOPTION:** People become convinced that the results are worth the effort and begin to practice the behavior on a regular basis.
5. **MAINTENANCE:** People keep up the behavior over time, until it becomes second nature, something they do almost without thinking.

Take a few minutes to think of a behavior change you went through at some point in your past. This might be something you stopped doing for one reason or another (smoking, eating too much fat, driving without your seat belt fastened, drinking too much alcohol) or some new behavior you decided to adopt (regular exercise, going to church, meditation, opening a savings account, joining a club). You have no doubt adopted several new behaviors since arriving in-country, and you may want to use one of these as your example. In any case, try to answer the following questions about this behavior:

1. How did you become aware of this behavior?
2. What made you become more interested in this behavior?
3. What made you decide to try this behavior?
4. Why did you decide to adopt it?
5. What has made it possible for you to maintain it?

SESSION PLAN

PART FIVE–SESSION 5.2:

FACTORS AFFECTING BEHAVIOR CHANGE

OVERVIEW

Now that Trainees understand the process of behavior change, they need to understand the factors that affect behavior change, both the positive factors which support or help people change their behavior and the negative factors which interfere with or prevent people from changing their behavior. In effect, these factors constitute the criteria against which any proposed solution or health intervention should be measured.

OBJECTIVE

By the end of the session the Trainees will be able to identify the factors that support and interfere with people changing their behavior.

TIME

30 minutes

MATERIALS

Blackboard

Handout: *Factors Affecting Behavior Change*

DELIVERY

STEP 1. Introduce the session by the overview above.

STEP 2. Distribute the handout and introduce the exercise. Go over the list of key factors that affect behavior change on the handout. Divide Trainees into three groups, assigning each group four or five of the factors. Have them discuss why these factors are important. Ask them to cite examples from their communities or their past experiences in their explanations. They should select a reporter to take notes and be prepared to report for their group.

STEP 3. Solicit and discuss their explanations. Discuss any questions they may have, and ask them if they can think of any other criteria that should be included on the list. Ask the Trainees to save this list for future reference.

STEP 4. Close by pointing out that in considering solutions to health problems in the community, people should evaluate any behavioral changes required by those solutions against these important criteria.

RESOURCE

Communication for Health and Behavior Change: A Developing Country Perspective

TRAINEE HANDOUT
PAGE 1 OF 2

FACTORS AFFECTING BEHAVIOR CHANGE

Now that you understand the process of behavior change, you need to be familiar with certain key factors which affect such change, making it more or less likely to take place. These factors are in effect the criteria against which any proposed solution or health intervention should be judged.

Below is a list of key factors that affect behavior change. Explain why you think each of these factors is important in promoting behavior change.

1. The target behavior addresses a major problem.

2. The community recognizes this as a major problem.

3. Similar or approximate behaviors exist in the community.

4. There is family support for the target behavior.

5. There is peer support for the target behavior.

6. Positive consequences are not long in coming.

7. There are observable positive consequences.

254

TRAINEE HANDOUT
PAGE 2 OF 2

FACTORS AFFECTING BEHAVIOR CHANGE

8. There are few or no negative consequences.

9. The target behavior does not conflict with cultural beliefs/customs.

10. The target behavior is too complicated or difficult:

    The target behavior
    - has too many steps
    - has to be done too often
    - is too time consuming
    - has to be done over too long a period of time

11. The target behavior is not too expensive.

12. People have the skills/knowledge needed to perform the action.

13. Any needed resources/assets are available in the community.

14. No competing behaviors exist.

SESSION PLAN

PART FIVE–SESSION 5.3:

EVALUATING TARGET BEHAVIORS

OVERVIEW

In the previous two sessions, the Trainees learned about the process of and the factors affecting behavior change. In this session Trainees practice applying the theory to actual health behaviors. This session exposes Trainees to 16 important health behaviors known to have a significant impact on one or more of the five common conditions which contribute to child mortality (see the session ***Common Causes of Child Mortality***, p. 38, and the booklet ***Facts For Life: A Communication Challenge***). As such, these behaviors would be obvious targets for any kind of health interventions Volunteers wanted to become involved in in their communities. The exercise has two purposes:

1. To familiarize Trainees with these important behaviors, since they are very likely to become involved in projects aimed at promoting these behaviors,
2. To allow Trainees to practice evaluating proposed behavioral changes according to the feasibility criteria established earlier.

The first part of the session asks Trainees to consider each behavior and decide which of the health problems already identified it might help eliminate. The second part asks Trainees to select one of these behaviors and analyze it according to the criteria affecting behavior change discussed in the last session ***Factors Affecting Behavior Change***, p. 227.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Identify behaviors which have been shown to be especially effective in combating childhood diseases.
2. Evaluate these behaviors according to the behavior change criteria.

TIME

30 minutes

MATERIALS

Handout: *Evaluating Target Behaviors*

From your In-Country Resource Center (IRC) or the Information Collection and Exchange (ICE) at Peace Corps headquarters, several copies of ***Emphasis Behaviors in Maternal and Child Health: Focusing on Caretakers' Behaviors to Develop Maternal and Child Health Programs in Communities*** (ICE # HE349)

Facts For Life: A Communication Challenge (ICE # HE231)

PREPARATION

Read the handouts and the steps in the lesson plan. Do each task to be sure it is clear and you can give examples.

DELIVERY

STEP 1. Introduce the session by the overview above. Distribute the handout. Ask the trainees to read the top of the page and the criteria. Answer any questions. Then have them read the 16 behaviors, as they are divided into categories.

STEP 2. Explain the task of Part One. Ask if there are any questions. Show the reference books and suggest that if they have any questions about which problem should go under which behavior, they may use ***Facts For Life*** and the booklet on ***Emphasis Behaviors*** as references. Divide them into groups of three or four and have them complete Part One as groups.

STEP 3. As a whole group, solicit their answers. Ask Trainees to explain why they put a given problem under a particular behavior.

STEP 4. With the whole group, read the directions to Part Two. Together, do the first target behavior to be sure everyone understands the task. Then assign each small group one or two different target behaviors to evaluate.

STEP 5. Ask each group to present one of the behavioral changes they analyzed and the decision they made. Ask them to justify the decision by referring to the criteria. If time permits, have each group present their second behavior.

STEP 6. When the groups are finished, ask them on what basis they would decide whether to proceed with a project if the answers to some of the criteria questions were yes and to others, no? How would they decide which criteria were essential and which were not?

STEP 7. Ask one or more of the Trainees to summarize the learnings from this session.

RESOURCE

Emphasis Behaviors in Maternal and Child Health: Focusing on Caretakers' Behaviors to Develop Maternal and Child Health Programs in Communities (ICE # HE349); ***Facts for Life: A Communication Challenge*** (ICE # HE231)

TRAINEE HANDOUT
PAGE 1 OF 4

EVALUATING TARGET BEHAVIORS

This exercise presents 16 behaviors that have been identified as especially effective in reducing child mortality in developing countries. They were selected because they all met the following important criteria:

1. They have an impact on the most important health problems in developing countries.
2. They have been well documented to reduce childhood morbidity and mortality.
3. They have broad public health importance by having an impact on multiple disease areas.
4. They are measurable.
5. They can be changed as a result of public health interventions already demonstrated as feasible and cost effective.

The 16 behaviors, divided into categories, are given below:

REPRODUCTIVE HEALTH PRACTICES: Women of reproductive age need to practice family planning and seek prenatal care when they are pregnant.

1. For all women of reproductive age, delay the first pregnancy, practice birth spacing, and limit family size.
2. For all pregnant women, seek prenatal care at least two times during the pregnancy.
3. For all pregnant women, take iron tablets.

INFANT AND CHILD FEEDING PRACTICES: Mothers need to give age-appropriate foods and fluids.

4. Breast-feed exclusively for about six months.
5. From about six months, provide appropriate complementary feeding and continue breast-feeding until 24 months.

IMMUNIZATION PRACTICES: Infants need to receive a full course of vaccinations; women of childbearing age need to receive an appropriate course of tetanus vaccinations.

6. Take infant for measles immunization as soon as possible after the age of nine months.

TRAINEE HANDOUT
PAGE 2 OF 4

EVALUATING TARGET BEHAVIORS

7. Take infant for immunization even when he or she is sick. Allow infant to be immunized during visit for curative care.

8. For pregnant women and women of childbearing age, seek tetanus toxoid vaccine at every opportunity.

HOME HEALTH PRACTICES: Caretakers need to implement appropriate behaviors to prevent childhood illnesses and to treat them when they do occur.

Prevention

9. Use and maintain insecticide-treated mosquito nets.

10. Wash hands with soap at appropriate times.

11. For all infants and children, consume enough vitamin A.

12. For all families, use iodized salt.

Treatment

13. Continue feeding and increase fluids during illness; increase feeding immediately after illness.

14. Mix and administer ORT, or appropriate home-available fluid, correctly.

15. Administer treatment and medications according to instruction (amount and duration).

CARE-SEEKING PRACTICES: Caretakers need to recognize a sick infant or child and need to know when to take the infant or child to a health worker or health facility.

16. Seek appropriate care when an infant or child is recognized as being sick (i.e., looks unwell, not playing, not eating or drinking, lethargic or change in consciousness, vomiting everything, high fever, fast or difficult breathing).

TRAINEE HANDOUT
PAGE 3 OF 4

EVALUATING TARGET BEHAVIORS

PART ONE

In your small group, consider how each of these behaviors affect the major health problems you have identified in/with your community. In the space beneath each behavior, write the name of any health problem you think this behavior would help eliminate. Remember that one health problem may be eliminated by several health behaviors on the list. In other words, you may write down a certain health problem under several behaviors.

The following gives some examples using the first five behaviors on the list:

REPRODUCTIVE HEALTH PRACTICES: Women of reproductive age need to practice family planning and seek prenatal care when they are pregnant.

1. For all women of reproductive age, delay the first pregnancy, practice birth spacing, and limit family size.

   Example: High infant mortality

2. For all pregnant women, seek prenatal care at least two times during the pregnancy.

   Example: High incidence of maternal mortality/morbidity

3. For all pregnant women, take iron tablets.

   Example: Iron deficiency anemia

INFANT AND CHILD FEEDING PRACTICES: Mothers need to give age-appropriate foods and fluids.

4. Breast-feed exclusively for about six months.

   Example: Infant mortality/morbidity due to diarrhea

5. From about six months, provide appropriate complementary feeding and continue breast-feeding until 24 months.

   Example: Malnutrition

TRAINEE HANDOUT
PAGE 4 OF 4

EVALUATING TARGET BEHAVIORS

PART TWO

Select one of these behaviors and imagine that the community you now live in is considering a health intervention with this behavior as the ultimate goal. Is this particular behavior a good target around which to plan an intervention? Evaluate this behavior according to the criteria given in the session **Factors Affecting Behavior Change**, p. 227, and repeated below. After considering all 14 criteria, determine whether or not your group thinks this behavioral change is a good target for the community. Be prepared to defend your decision.

1. Does the target behavior address a major health problem?
2. Does the community recognize this as a major problem?
3. Do similar or approximate behaviors exist in the community?
4. Is there family support for the target behavior?
5. Is there peer support for the target behavior?
6. Will positive consequences occur relatively soon?
7. Are there observable positive consequences?
8. Are there few or no negative consequences?
9. Does the target behavior conflict with cultural beliefs/customs?
10. Is the target behavior too complicated or difficult?
    - too many steps
    - has to be done too often
    - too time consuming
    - has to be done over too long a period of time
11. Is the target behavior too expensive?
12. Does the target audience have the skills/knowledge needed to perform the action?
13. Are the resources/assets needed for the behavior available in the community?
14. Do any competing behaviors exist?

SESSION PLAN

PART FIVE–SESSION 6:
IDENTIFYING SOLUTIONS

OVERVIEW

Now that Trainees understand more about causes and about how behavior changes, this session asks them to think about and propose solutions to health problems, and practice evaluating the solution to determine their feasibility. The process here is to first make the distinction between a solution (Part Two) and an intervention or a means to a solution (Part One) and then to reexamine the causes of the health problems they identified earlier and brainstorm solutions to those causes. In Part Three of the exercise, Trainees will subject those solutions to the behavior change criteria to help determine whether that solution is feasible in the community.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain the concepts of solution and intervention, and distinguish between the two.
2. Practice identifying solutions to health problems.
3. Practice evaluating proposed solutions against behavior change criteria.

TIME

45–60 minutes

MATERIALS

Flip chart paper and markers
Handout: *Identifying Solutions*

DELIVERY

STEP 1. Explain the three parts of the session.

STEP 2. Distribute the handout. Go through Part One together.

ANSWERS:

1. Solution
2. Solution
3. Intervention
4. Intervention
5. Intervention
6. Solution
7. Solution
8. Intervention
9. Intervention

STEP 3. Review Parts Two and Three with the whole group. Ask Trainees to form groups and have them work on Parts Two and Three. Groups should work on one problem. Check to be sure they don't all work on the same initial problem. Have each group record its work on a flip chart.

STEP 4. Reconvene the groups and ask each to report out. Discuss their work and make any additions or corrections others suggest.

STEP 5. Discuss the implications evaluating solutions. A solution may not always meet every one of the criteria, but that does not necessarily mean that it should be discarded. It has to meet enough of the criteria that it is realistic to expect people in this community to do this particular thing.

STEP 6. Close by pointing out that now that we have some solutions to health problems, the next step is to select and design an intervention that will help bring that solution about.

Trainee Handout
Page 1 of 4

Identifying Solutions

After you have identified major child health problems in a community and understood the causes, the next step is to conceive of possible solutions.

It's very important at this stage not to confuse a solution with the means to a solution, which this training calls an intervention. A solution is an end or a goal and almost always involves a specific change in behavior on the part of mothers or other child care providers. If diarrhea is a child health problem, then a solution would be for mothers to wash their hands before preparing food. Another solution would be for mothers to boil all drinking water.

The *means* to a solution, the intervention, is any action which brings about the actual goal or end that is desired. Using the above example, the intervention to bring about the desired end—mothers washing their hands—could be any number of things: a poster campaign, a health talk at the local women's club, a fund-raiser to provide money for water filters, a door-to-door campaign, or the training of health care workers at the local clinic to give a health talk, mount a poster campaign, or conduct a fund-raiser. A health talk, in other words, is not a solution to the problem of diarrhea; mothers washing their hands is. But a health talk is the intervention that might get mothers to start washing their hands.

Solutions solve or eliminate problems. Interventions are the ways solutions get implemented.

Part One:

This brief exercise asks you to distinguish a solution from an intervention. In the following list of items, put an **"S"** next to any solution and an **"I"** next to any intervention.

1. ________ Putting up window screens.
2. ________ Increasing fluids for a child with diarrhea.
3. ________ Making visual aids for a talk on malnutrition.
4. ________ Training health care workers to give tetanus shots.
5. ________ Convincing a village leader to support a health fair in the local marketplace.
6. ________ Bringing a sick child to the clinic for examination/treatment.
7. ________ Using a birth control method to improve birth spacing.
8. ________ Raising money for the clinic to buy measles vaccine.
9. ________ Getting funds to buy window screening.

TRAINEE HANDOUT
PAGE 2 OF 4

IDENTIFYING SOLUTIONS

PART TWO:

BRAINSTORMING SOLUTIONS. After identifying the community's major health problems and their causes, the next step is to propose solutions. Any solution should be aimed at eliminating one or more causes of a problem (or possibly multiple problems, since some problems have similar causes). In brainstorming possible solutions, keep the following points in mind:

1. A solution normally addresses the immediate causes of a problem (as opposed to the ultimate causes).
2. A solution should solve the problem by stopping, preventing, eliminating, or partially eliminating the problem.
3. A solution should be stated in the form of a specific action, actions, or behavior; something you want someone to do, to do differently, or to stop doing.

With your group, select a health problem and then look at the various causes of the problem that you have already listed. For each cause, try to come up with one or more possible solutions and list them below. At this point, don't worry about whether or not the solution is feasible. Just make sure it *is* a solution, i.e., something which would eliminate (or help eliminate) that particular cause. For the moment, don't worry about how you would implement these solutions.

HEALTH PROBLEM: ______________________________

CAUSE 1: ______________________________

SOLUTIONS: ______________________________

____

____

CAUSE 2: ______________________________

SOLUTIONS: ______________________________

____

____

CAUSE 3: ______________________________

SOLUTIONS: ______________________________

____

____

TRAINEE HANDOUT
PAGE 3 OF 4

IDENTIFYING SOLUTIONS

PART THREE:

EVALUATING SOLUTIONS. Now that your group has identified some possible solutions for the health problem you have selected, you should decide whether or not these solutions are feasible, that is, is it realistic to expect people in this community to do these particular things? Select three or four of the solutions you have come up with and then subject them to the criteria developed in the session **Factors Affecting Behavior Change** and below. For each solution you decide to analyze, think of the particular behavior change it would require and then decide if that change is feasible for the target audience in your community.

SOLUTION WORKSHEET

Try to answer these questions for the proposed solution you have in mind:

1. Does the target behavior address a major health problem?

2. Does the community recognize this as a major problem?

3. Do similar or approximate behaviors exist in the community?

4. Is there family support for the target behavior?

5. Is there peer support for the target behavior?

6. Will positive consequences occur relatively soon?

7. Are there observable positive consequences?

Trainee Handout
Page 4 of 4

Identifying Solutions

8. Are there few or no negative consequences?

9. Does the target behavior conflict with cultural beliefs/customs?

10. Is the target behavior too complicated or difficult?
    - has too many steps
    - has to be done too often
    - is too time consuming
    - has to be done over too long a period of time

11. Is the target behavior too expensive?

12. Does the target audience have the skills/knowledge needed to perform the action?

13. Are the resources/assets needed for the behavior available in the community?

14. Do any competing behaviors exist?

There is no magic formula for deciding whether a proposed solution or behavior change is a feasible idea for your community. After you have subjected the proposed solution and intervention to the above evaluation, decide whether, *on balance*, this still seems like a good idea. If you have been going through this process with counterparts or other nationals, as you would be at your site, chances are there will be general agreement.

SESSION PLAN

PART FIVE–SESSION 7:
SELECTING AN INTERVENTION

OVERVIEW

Now that the Trainees have conceived of solutions to health problems and determined their feasibility, they are ready to select appropriate interventions. An intervention is a *means* to a solution and is any action which brings about the actual goal or end that is desired. Solutions solve or eliminate problems and interventions are the ways solutions get implemented.

OBJECTIVE

By the end of the session the Trainees will be able to practice identifying interventions for child health problems.

TIME

30 minutes

MATERIALS

Flip chart paper or blackboard

Handout: *Selecting an Intervention*

DELIVERY

STEP 1. Explain the purpose of the exercise and distribute the handout. Go over the list of possible interventions and add any other interventions you can think of.

STEP 2. Divide Trainees into groups and ask each group to select a major health problem worked on and review its solutions. Make sure each group selects a different problem. Using the handout and a flip chart page, the group should brainstorm interventions to each of the listed solutions.

STEP 3. Have each group post its flipchart. Ask Trainees to move around to each flip chart, reading the interventions and adding any others they think of. Have them put a question mark by any that they question as not feasible or appropriate.

STEP 4. Have the total group reconvene. Ask each group to respond to any comments or questions on their list.

STEP 5. Close by asking the group why this exercise is important and how they might apply this skill once they are at their site.

TRAINEE HANDOUT
PAGE 1 OF 3

SELECTING AN INTERVENTION

After identifying the community's major health problems and their causes, and looking at solutions to those problems, the next step is to come up with interventions or the means to those solutions. **An intervention is an activity or activities that could be carried out in the community.** Interventions often involve awareness building, giving information, and getting people interested in adopting a solution. Some interventions may require community organization and support. In selecting your interventions, take into account the culturally appropriate ways people communicate and the traditional ways people learn in this culture. Also consider the common ways people organize themselves to get things accomplished.

The following is a list of possible interventions:

A. Projects:

1. Starting kitchen gardens
2. Building latrines
3. Building smokeless fireplaces
4. Putting in a potable water system
5. Holding garbage collection campaigns
6. Holding immunization campaigns or clinics
7. Holding a vitamin A campaign
8. Starting or working in a well baby clinic, MCH clinic, or family planning clinic
9. Doing growth monitoring of children under five
10. Starting or working in a campaign for eradicating polio, guinea worm, or other health problems
11. Doing a fund raiser for a solution that requires monetary resources
12. Starting or working in an income-generation project
13. Starting or working with a cooperative
14. Establishing a revolving fund in the community to buy medicines and supplies for the clinic
15. Starting or working in a campaign to promote iodized salt, iron-rich foods, etc.
16. Providing community workshops on starting a project or other topics
17. Providing in-service training for health workers, traditional birth attendants, or traditional healers
18. Starting or working in a program for community health volunteers
19. Training community health volunteers
20. Training teachers
21. Training peer groups
22. Developing a health curriculum for the schools
23. Starting literacy classes incorporating health topics

TRAINEE HANDOUT
PAGE 2 OF 3

SELECTING AN INTERVENTION

B. Health Education Activities:

1. Health talks with individuals or groups
2. Health fairs
3. Role plays
4. Skits
5. Puppet shows
6. Games for children
7. Story telling
8. Village theater or socio-dramas
9. Poster campaigns
10. Mass media campaigns
11. Door-to-door campaigns
12. Filmstrips, slide shows, videos
13. Demonstrations

With your group, select one of the health problems you have already worked on and look at the various solutions that you have listed. For each solution, try to come up with one or more possible interventions and list them below. You may use interventions from the list above and you may think of other interventions that would work in your community or the culture that you are living in. One person in your group should do this activity on a flip chart.

HEALTH PROBLEM A: ____

SOLUTION 1: ____________________	**SOLUTION 2:** ____________________
INTERVENTIONS: ________________	**INTERVENTIONS:** ________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________
____________________________	____________________________

TRAINEE HANDOUT
PAGE 3 OF 3

SELECTING AN INTERVENTION

SOLUTION 3: ____________________

INTERVENTIONS: ____________________

SOLUTION 4: ____________________

INTERVENTIONS: ____________________

HEALTH PROBLEM B: ____________________

SOLUTION 1: ____________________

INTERVENTIONS: ____________________

SOLUTION 2: ____________________

INTERVENTIONS: ____________________

HEALTH PROBLEM C: ____________________

SOLUTION 1: ____________________

INTERVENTIONS: ____________________

SOLUTION 2: ____________________

INTERVENTIONS: ____________________

SESSION PLAN

PART FIVE–SESSION 8:

DESIGNING AN INTERVENTION 1: COMMUNITY ASSETS

OVERVIEW

As they start to think about designing an intervention, Trainees should be aware of what assets are available in the community in general. This session asks them to review their notes for the assets they identified in the data collection part of their training and record them here. If Trainees have thought of other assets they can add them now.

OBJECTIVE

By the end of the session the Trainees will be able to list a variety of community assets.

TIME

30 minutes

MATERIALS

Handout: *Designing an Intervention 1: Community Assets*

Blackboard

DELIVERY

STEP 1. Introduce the activity and distribute the handout.

STEP 2. Divide Trainees into work groups.

STEP 3. Reconvene the groups. Ask for a few examples from each category.

TRAINEE HANDOUT
PAGE 1 OF 2

DESIGNING AN INTERVENTION 1: COMMUNITY ASSETS

Now you have reached the stage where you will practice the skill of designing an intervention, that is, a series of actions that will help bring about one or more solutions to a particular health problem. By definition, an intervention is going to require resources or assets, whether human, financial, or material. In an earlier stage of your training, as part of your community analysis, you recorded assets as you found them in your community.

This exercise asks you to review the information you collected earlier and list community assets here. You should, in addition, add any assets you can think of that you did not see earlier. Think very broadly for the moment; don't worry at this point about how a particular asset might be used. Several examples have been given to start you thinking.

PEOPLE

Available skills/ expertise:	plumber nurse civil servant
Available labor:	
Available influence:	cousin of the governor brother of bank manager

ORGANIZATIONS OR GROUPS

Formal entities:	town council school board hospital volunteer committee church groups
Informal entities:	women who meet at the well every morning men who meet at the tea shop or local bar
Clubs	soccer team music club

DESIGNING AN INTERVENTION 1: COMMUNITY ASSETS

FACILITIES/INFRASTRUCTURE

hospital
water source
drugstore
bus service

MATERIAL GOODS

vaccines

trucks

FINANCIAL

access to loans

access to grants

seasonal work for salary

OTHER

Session Plan

Part Five–Session 9:

Designing an Intervention 2: The Process

Overview

This activity gives Trainees a chance to practice designing a health intervention so that they understand the process from start to finish.

Objectives

By the end of the session the Trainees will be able to:

1. Define the steps of designing a health intervention.
2. Design a health intervention.

Time

1 hour

Materials

Handout: *Designing an Intervention 2: The Process*

Extra copies of the Design Process grid.

Delivery

STEP 1. Introduce the session. Emphasize that it is not because they will or should be designing interventions on their own as Volunteers (though they may on occasion) that they are completing this exercise. They need to understand the complete process in order to be able to advise or work with other people who may be doing it.

STEP 2. Distribute the handout. Go through the steps referring to the example. Point out that the example is a relatively simple intervention which one person could do on their own. (Unless you have already done the sessions on **Monitoring and Evaluating an Intervention**, p. 271, tell Trainees they will not have to complete Step 6 at this time.)

STEP 3. Divide Trainees into groups and have each group create a design following the six steps. Encourage them to pick an intervention that is more involved and multifaceted than the example, so they can be exposed to more of the subtleties and intricacies of this skill. Tell them that they will learn more about monitoring and evaluation in sessions on **Monitoring and Evaluating an Intervention**, p. 271 and p. 280, but that they should be thinking about it now as part of the design process

STEP 4. Reconvene the groups and have each small group present its design. Provide extra design grids so that Trainees can record any of the designs they wish to. Discuss the design process: What steps were the most difficult? How were they able to involve the community in the design?

STEP 5. If Trainees are now going to go through this process with members of the community (see the next session in the manual), you should do any necessary preparation for/discussion of this meeting at this time.

TRAINEE HANDOUT
PAGE 1 OF 6

DESIGNING AN INTERVENTION 2: THE PROCESS

Thus far in your training, you have learned and practiced the following skills:

- ✓ Gathering information on your community, the context in which you would be serving as a Volunteer.
- ✓ Identifying the major child health problems in and with your community.
- ✓ Identifying the causes of those problems.
- ✓ Learning about behavior change, the means by which most health problems ultimately are solved.
- ✓ Identifying solutions to one or more major problems.
- ✓ Selecting an appropriate intervention.

Now you are in a position to put them all together and design a health intervention. The steps in designing such an intervention are as follows:

DESIGN PROCESS

STEP 1. Select a problem.

STEP 2. Identify who is affected by the problem.

STEP 3. Identify a solution to the problem.

STEP 4. Select an intervention.

STEP 5. Identify the steps required to carry out the intervention.

STEP 6. Design a monitoring and evaluation plan.

In this exercise, you will work with the other members of your small group to go through these six steps and design an actual intervention. Attached you will find an example to use as a guide and a blank grid to fill in as you complete each step in your small group.

TRAINEE HANDOUT
PAGE 2 OF 6

DESIGNING AN INTERVENTION 2: THE PROCESS

STEP 1: Select a problem.

Your group first needs to identify a major health problem you intend to address. Refer back to your notes from the session **Analyzing the Data**, p. 206, and select one of the Key Health Problems you identified at the end of that activity.

STEP 2: Identify who is affected by the problem.

Having selected a problem, you now need to decide who is affected by this problem in other words, who is your potential target audience for your intervention. Brainstorm all the possible populations affected by the problem and then select one or more audiences to be the target group for your intervention.

STEP 3: Identify a solution to the problem.

Having identified a problem and a target audience, your group now needs to devise a solution to the problem appropriate to the audience. You will remember that part of devising a solution is to correctly identify the cause or causes of the problem. Refer back to your notes from the session **Causes of a Health Problem**, p. 218, and the session **Identifying Solutions**, p. 238, to guide you in both devising and evaluating possible solutions.

STEP 4: Select an intervention.

Now that you have devised a solution, you need to select an intervention, a means to implement your solution. Refer to your notes for the session **Selecting an Intervention**, p. 244, as you complete this step of the design process.

STEP 5: Identify the steps required to carry out the intervention.

This and the next step are the only steps of this entire design process that you have not already practiced in previous exercises. Your job here is to decide what tasks will have to be done in order to achieve/accomplish the intervention. Refer to the attached example for guidance. As you list the various steps, be sure to answer the following questions for each one:

- Who should take the action?
- How that action will be accomplished?
- When it should be done?
- What resources will be needed?

These four items appear on your grid (and on the example grid) and should be filled in by your group as you complete this step.

STEP 6: Design a monitoring and evaluation plan.

This is an important step in designing an intervention, but you will not be able to do this until you have completed the sessions on **Monitoring and Evaluating an Intervention**, p. 271 and p. 280. When you have done those exercises, be sure to return to this design and complete this step.

DESIGN PROCESS GRID

Design Process	Example	Who Should Take Action	How	When	Resources
1. Select a problem:	Diarrhea	PCV with counterpart and community	Gathering information on the problems and their causes and analyzing it	After doing an analys of the problems and their causes	Data gathered, existing data, community, health workers, etc.
2. Identify who is affected	Children under five	PCV with counterpart and community	Analysis of the problems and their causes	During the analysis of the problem	Data gathered, existing data, health workers, etc.
3. Identify solution to the problems	Get mothers to wash their hands before preparing the child's food	PCV with counterpart and/or community	Solution analysis using behavior change criteria. Focus groups with health workers and/or mothers	After doing an analysis of the problems and their solutions	Community, health workers, mothers, etc.
4. Identify intervention	Give a health talk to a woman's group (or mother's club)	PCV with counterpart and/or community	Focus group with health workers and/or mothers	After identifying solutions	Community, health workers, mothers, etc.

BEST COPY AVAILABLE

DESIGN PROCESS GRID

Design Process	Example	Who Should Take Action	How	When	Resources
5. Identify steps to carry out the intervention	1. Get permission to address the women	1. PCV with counterpart	1. Meet with the leader of the women's group	1.	1.
	2. Decide on the time and place	2. PCV with counterpart and/or group leader	2. With the women's group	2. When women are available, where they usually meet	2. Timeline activity
	3. Spread the word	3. Women's group leader; other community leaders	3. Posters; radio spots; mass media campaign	3. Several weeks before event	3. Money; people with influence; materials for posters
	4. Prepare the talk	4. PCV and counterpart or health worker	4. Using techniques from health education module	4. Several days prior to event	4. Health education materials
	a. decide on content b. prepare visual aids c. practice				4b. Materials for visual aids; organizations that have visual aids already prepared
	5. Give the talk	5. PCV and counterpart or health worker			
6. Design monitoring	1. Establish baseline data	PCV with counterpart and/or women's group	Meet to decide on goal(s) and indicators	As part of the planning process	PCV, counterpart(s) and selected members from the women's group
	2. Set project goals and indicators				
	3. Monitor project using indicators				
	4. Make adjustments or changes to the project as necessary				
	5. Evaluate actual work completed to measure the overall success of the project				

BEST COPY AVAILABLE

DESIGN PROCESS GRID

Design Process	**Example**	**Who Should Take Action**	**How**	**When**	**Resources**
1. Select a problem:					
2. Identify who is affected by the problem:					
3. Identify solution to the problem:					
4. Identify intervention :					
5. Identify steps to carry out the intervention: 1. 2. 3. 4. 5. 6.					

DESIGN PROCESS GRID

Design Process	Example	Who Should Take Action	How	When	Resources
6. Design monitoring and evaluation plan					
1.					
2.					
3.					
4.					
5.					288
6. 287					

SESSION PLAN

PART FIVE–SESSION 10.1:

DESIGNING AN INTERVENTION WITH THE COMMUNITY

OVERVIEW

Now that the Trainees have learned the theory behind and practiced the steps of designing an intervention on their own, they apply this knowledge and these skills with the community. During this session the Trainees meet with some members of the community and design an intervention following the steps in the design process as defined in the previous session **Designing an Intervention 2: The Process**.

In "real life," the Volunteer would be working with the community over a long period of time and would be helping the community to select a problem, solution, and intervention that can be carried out in a longer time-frame. The focus here is to learn how to work with the community in designing an intervention and to come up with an intervention and plan that can be carried out during PST. This means the intervention has to be meaningful to the needs of the community, yet simple and easily implemented.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Design an intervention with the community.
2. Develop a plan for implementing this intervention with the community.

TIME

2 hours

289

MATERIALS

Blackboard

Flip chart of the list of priority health problems that was created in the previous community meeting (the session **Analyzing the Data with the Community**, p. 212.)

Flip chart with criteria or Key Factors that Affect Behavior Change from the session **Factors Affecting Behavior Change**, p. 227.

Flip chart with the Design Process grid (blank) from the session **Designing an Intervention 2: The Process**, p. 252.

STAFF

Invite the APCD to attend and/or facilitate the meeting. (In some cultures, having a person such as the APCD present gives credibility and importance to the meeting in the eyes of the community.)

If the APCD is not available, invite one or several of the language trainers to come to the meeting and act as translators if needed.

PREPARATION

Prior to this session meet with the community leaders and explain the purpose of this community meeting. Ask the community leaders for their input and advice on who should attend, and set a date, time, and place for the meeting. Ask them to invite the community members to the meeting. Check out the meeting place to see what the set-up is: What is the seating arrangement? Are there plenty of chairs available? Is there a blackboard and chalk (or flip chart) available and a table to use, etc.?

Prepare the Trainees for the meeting by explaining the purpose, the venue/date/time, who will be attending, who will be facilitating, and how the meeting will proceed (steps 1–5 below).

Select and prepare a facilitator for the meeting. This may be the APCD/Health, the technical trainer, and/one of the Trainees (if their language skills are adequate). If the facilitator is not a Trainee or person who has learned the process of designing an intervention as explained in this manual, then you will need to train the facilitator in the intervention design process.

Delivery

STEP 1. Ask the spokesperson or community leader to introduce the meeting. Then introduce the APCD and/or facilitator, the Trainees, and any language staff present.

STEP 2. Ask the facilitator to take charge of the meeting and carry out the remaining steps.

STEP 3. Begin by explaining that in the previous community meeting, you discussed and prioritized the health problems in the community and now you will be looking at the causes of the problem and possible solutions. Then you will decide on an appropriate and feasible intervention.

STEP 4. Post the flip chart with the blank design process grid and explain to the community that this is one way of systematically designing an intervention. As you go through each step, fill in the blanks in the grid. Then lead the community through the steps of the design process:

Select a problem: Put up the flip chart of the list of priority health problems that was created in the previous meeting. Ask the community members to look at this list and decide which problem they would like to address. Write this in the blank next to "Select a problem."

Identify who is affected by this problem: Brainstorm all the possible populations affected by the problem and then select one or more audiences to be the target group for your intervention.

Identify a solution to the problem: Ask the community members what they think are the causes of this problem. List each cause on the flip chart leaving a space below each one. For each cause, ask the community members to come up with one or more possible solutions. List them under the corresponding cause. Make sure that what they come up with are solutions and *not* interventions.

Select three or four of the solutions the community has come up with and then discuss them in reference to the criteria or key factors that affect behavior change using the flip chart of **Key Factors that Affect Behavior Change**. Discuss each of the factors with the community members for each solution the community has selected. Ask them to think of the particular behavior change it would require and then decide if that change is feasible for the target group in their community. Using this process, you should now be able to narrow the list down to one solution.

Select an Intervention: Discuss possible interventions for the solution with the community members and select one intervention that can be carried out during the time the Trainees are in the community (i.e., before the end of PST).

Identify the steps required to carry out the intervention: Ask the community members to decide what tasks need to be done in order to achieve/accomplish the intervention. As they come up with the various steps, be sure they answer the following questions for each one:

- Who should take action?
- How that action will be accomplished?
- When it should be done?
- What resources will be needed?

When discussing resources needed, ask the group to look at what assets are available in the community.

The above four items appear on the grid. Fill the grid in as each step is completed.

Design a monitoring and evaluation plan: Explain briefly that an important part of any intervention is to monitor its progress and evaluate its effectiveness/success in meeting the health needs of the community. Ask the community to select several of its members who are active in the community and would be interested in learning more about monitoring and evaluating the intervention. Set a date, time, and place to meet with this group. This meeting should take place *after* the Trainees have learned how to design a monitoring evaluation plan (the session **Monitoring and Evaluating an Intervention**, p. 271).

STEP 5. Close the meeting by thanking the community leaders and community members for coming and telling them that you and the Trainees look forward to carrying out the intervention with them.

RESOURCE

Gender and Development Training Manual, Booklet 6

SESSION PLAN

PART FIVE–SESSION 10.2:

PROCESSING THE SESSION ON IDENTIFYING SOLUTIONS AND SELECTING AN INTERVENTION WITH THE COMMUNITY

OVERVIEW

In order for the Trainees to learn from their experience of conducting or participating in a community meeting, it is very important that they meet and process that experience. By doing this, they learn what is important to the community, how the community members perceive the causes of health problems, and how a community becomes actively involved in coming up with solutions and designing an appropriate intervention.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss their experience and findings from the meeting with the community.
2. Compare their own perceptions and ideas of the causes/solutions/interventions to health problems with those of the community.
3. Explain how to get the community actively involved in coming up with solutions and carrying out an appropriate intervention.

TIME

15–20 minutes

MATERIALS

Flip charts generated in the community meeting, translated into English if necessary.

STAFF

If the trainer is not familiar with the norms of organizing and conducting a community meeting in this culture, they may ask the APCD, the cross-cultural coordinator, and/or some of the language staff to assist with this session.

DELIVERY

STEP 1. Explain the purpose of this session. Look at flip chart of the design process grid generated with the community. Discuss any differences they may find between the community's perceptions and their own.

STEP 2. Discuss the dynamics of the meeting. Ask the Trainees what their observations of the meeting were and discuss these. Then ask the facilitator to discuss the experience of facilitating the meeting—what worked, what didn't, things to do differently, etc. Ask the APCD, cross-cultural coordinator, and/or language instructors to answer any questions and explain the dynamics of the meeting from a cross-cultural point of view.

STEP 3. Summarize the session by listing lessons learned. Suggest Trainees might want to keep notes on this. Discuss the intervention(s) that the Trainees will be carrying out with the community and plan the next steps. Carry out the interventions as planned. Then evaluate the interventions per the session **Evaluating an Intervention**, p. 280.

RESOURCES

Community Assessment and Planning for Maternal and Child Health Programs: A Participatory Approach in Ethiopia; Gender and Development Training Manual, Booklet 6

SESSION PLAN

PART FIVE–SESSION 11.1:
MONITORING AND EVALUATING AN INTERVENTION: ESTABLISHING BASELINE DATA

OVERVIEW

One of the most important, and often overlooked, steps in any intervention is designing and putting in place a monitoring and evaluation system. Monitoring is a way to measure the progress or lack of progress of any program, thereby giving program designers/implementers the feedback they need in order to know if their intervention is actually working and the opportunity to change it if it is not. The first step in designing a monitoring system is to establish baseline data.

Special Note: Each Peace Corps project should have a monitoring and evaluation plan in place. This plan provides the Volunteers with a method for reporting to their APCD and a means for the APCD to monitor and evaluate their projects. The sessions in this manual teach the theory behind monitoring and evaluation, and provide the Trainees with the skills to do it, but the APCD may have a slightly different plan and method in place which meets the Peace Corps project's needs. Therefore, the technical trainer should schedule a separate session in which the APCD can address project needs and tell the Trainees how they should report to Peace Corps.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss the concepts of monitoring and evaluation.
2. Discuss the concept of baseline data.
3. Practice establishing baseline data.

TIME

20–30 minutes

MATERIALS

Handout: *Establishing Baseline Data*

STAFF

Invite the APCD/Health to participate in these sessions so that s/he is aware of the principles and methodology being presented to the Trainees and can link them to monitoring and evaluation needs of the project.

DELIVERY

STEP 1. Explain the purpose of this session. Emphasize that when Trainees are working on baseline data, they should include their counterparts or whoever they are working with. However, they need to understand the process in order to be able to advise or work with other people who may be doing it.

STEP 2. Divide the Trainees into three groups. Assign one of the three health problems to each group and ask them to read the examples and answer the two questions for their health problem. Distribute the handout *Establishing Baseline Data.*

STEP 3. Bring the groups back together and ask each group to report their results. Briefly discuss their ideas and add anything you think is missing.

ANSWERS: Question 1–Information needed:

Acute Respiratory Infections (ARI)
Total number of children in the community
Total number of children who suffer from ARI
Number of homes that already have smokeless fireplaces

Malnutrition
Total number of children in the community
Total number of children who suffer from malnutrition

Dehydration
Total number of children in the community
Total number of children who suffer from diarrhea and dehydration

ANSWERS: Question 2–Where to get the information:

- Trainee/child health notebooks
- Observations
- Interviews
- Surveys

- Clinic records; mothers' records
- Statistics from the district health office or MOH
- Statistics from NGOs, such as UNICEF, who may be working in the area
- Talking with the leaders in the community
- Talking with health workers, mothers, etc.
- Home visits

STEP 4. As preparation for the next exercise, either give each group some baseline data (see examples below) or ask each group to come up with their own hypothetical baseline data for each item they have identified in step 2 above. They or you should make up a figure for the total population of children in the community and the number of sick children suffering from ARI, malnutrition, or dehydration. Have them divide the number of sick children by the total number of children to get the percentage of sick children in a given community. For example, 100 children suffering from measles divided by 1000 children (total in community) = 10% infant morbidity. Be sure to save this data for use in the next exercise.

Examples of hypothetical baseline data:

Example 1:
1000 children in the community
330 children suffer from ARI per year
30 homes have smokeless fireplaces

Example 2:
600 children in the community
300 children are malnourished

Example 3:
400 children in the community
100 children suffer from diarrhea and dehydration per year

STEP 5. Note that in the next session, Trainees will learn how to set project goals and measure progress based on baseline data such as they worked on in this session.

TRAINEE HANDOUT
PAGE 1 OF 2

ESTABLISHING BASELINE DATA

In the previous exercise, you designed an appropriate health intervention, which included a monitoring and evaluation system. In this series of exercises, you will go through the steps of designing such a system, beginning with the establishment of baseline data.

Baseline data is a kind of snapshot of the way things are, the existing conditions at the time you begin your intervention. It is the "before" photo that you will eventually compare with the "after" photo to determine what your intervention has accomplished. Without baseline data as a point of reference, it's impossible to measure the progress, or lack thereof, of your project.

EXAMPLE:

> Chandrapur is a small village in India. The last census reported that there were 1,000 children under the age of five. Every year 100 children suffer from measles or measles-related illnesses. The District Health Office (DHO) has identified this as a major health problem and has instituted a measles vaccination program. The District Health Officer and staff began with a mass media campaign aimed at getting mothers to bring their children in to the local clinic for the measles vaccine. A monitoring and evaluation program was put into place to measure the progress and outcomes of the program.
>
> Based on the above statistics, the DHO established that there was a 10% infant morbidity from measles. This statistic describes the existing situation *vis-à-vis* childhood measles at the start of the project. Later, at the conclusion of the project, the situation will be assessed again and then compared with this baseline data to determine the impact of the intervention.

You will notice how in this example the baseline data was arrived at using other key pieces of information. You will now be given a similar example to work on in your small group. Read the background information and try to answer two questions:

1. What pieces of information will you need in order to calculate your baseline data?
2. Where will you be able to find such information in your community/country?

TRAINEE HANDOUT
PAGE 2 OF 2

ESTABLISHING BASELINE DATA

Acute Respiratory Infections

A high percentage of the children in this community suffer from acute respiratory infections. You and your counterpart approach the community leaders and discuss the problem. The leaders form a health committee and together you analyze the problem and identify the proximate cause as smoky kitchens (with little ventilation where the mothers watch their children while they are cooking). Using the behavioral change criteria, the committee decides that introducing smokeless fireplaces to mothers in the community and motivating them to use them is one means of addressing this problem. In order to measure the success of this intervention, you will need baseline data. What information do you need and where and/or how do you get it?

Malnourishment

In this remote village many of the children are malnourished. Working with a local mothers' club, you, the Volunteer, analyze the problem and look at various solutions. Based on the behavioral change criteria, you and the women in the mothers' club decide to start a program to show mothers how to feed their children the proper weaning foods. In order to measure the success of this intervention, you need baseline data. What information do you need and where and/or how do you get it?

Dehydration

The majority of children under five come into the local clinic with dehydration caused by diarrhea. The health workers and you analyze the problem and look at causes and various solutions. Based on the behavioral change criteria, the health workers and you decide to start a health education program to teach the mothers about using ORT as their intervention. In order to measure the success of this intervention, you need baseline data. What information do you need and where and/or how do you get it?

SESSION PLAN

PART FIVE–SESSION 11.2:

MONITORING AN INTERVENTION

OVERVIEW

This two-part session teaches Trainees how to set project goals and how to measure progress towards those goals by creating and monitoring indicators. The first part of the session allows Trainees to become familiar with the two types of indicators they are most likely to be working with. The second part takes them through the process of designing a goal and then creating indicators to monitor progress towards that goal, using the example used in the previous exercise.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Discuss the concept of project goals and the types of indicators.
2. Practice establishing a monitoring system using goals and indicators.

TIME

30–60 minutes

MATERIALS

Handout: *Monitoring an Intervention*

DELIVERY

STEP 1. Introduce the session using the overview above.

STEP 2. Distribute the handout *Monitoring an Intervention* and go over the definitions of monitoring and indicators and discuss, as necessary, the Chandrapur example.

STEP 3. Give Trainees a few minutes to complete Part One. The answers here are as follows:

1. OP
1. OC
2. OC
2. OP
3. OC
3. OP
4. OP
4. OC
5. OP
5. OC
6. OP
6. OC

Lead a brief discussion on why it is important to know about and be able to distinguish between these two types of indicators. The key point is that if you only set up and monitor output indicators, you will only know what you did, not whether what you did worked.

STEP 4. Now send Trainees back into their three groups to go through the steps of setting up a monitoring system, as indicated on the worksheet. If they haven't already filled in baseline data (compiled at the end of the previous session's exercise as Step 4), have them do so first. Then give them at least half an hour to discuss and complete the remaining three tasks.

STEP 5. Reconvene the groups and have them report on the systems they set up.

TRAINEE HANDOUT
PAGE 1

MONITORING AN INTERVENTION

Now that you have established your baseline data, you are ready to identify a goal or goals for your intervention and then design a monitoring system to keep track of these goals. This two-part exercise will walk you through this process.

A goal is a statement of what you hope to accomplish by means of your intervention. It typically contains the three elements described below, using the Chandrapur case as our example:

1. **Who:** the target audience for your intervention. The District Health Officer (DHO) decided that children under age five were his target audience.
2. **How many:** how many of the target audience you are planning to reach via your intervention. The DHO decided he would try to immunize 80% of the children under age five.
3. **By when:** the time by which you expect to reach the goal. The DHO decided his goal was to immunize 80% of the children under age five by the end of two months.

Once you have established your goal, you are ready to think about a monitoring system. The purpose of monitoring is to keep track of the progress you are making toward your goal, which in turn allows you to make adjustments to your intervention in the event project goals are not being attained.

In order to monitor an intervention, you need indicators which are, as the word suggests, indications or signs that the project is on track, that it is producing the results envisioned and described in the goal. In the Chandrapur case, the DHO decided his indicator would be the immunization of 100 children per week. If he achieved this rate, he would know that his intervention was on target, for he would reach his goal of immunizing 80% of the children under age five (800 children) by the end of two months (100/week x 8 weeks = 800 children)

There are three classic types of indicators, described below:

1. Services, products, or contacts, such as the number of vaccinations given, the number of smokeless fireplaces built, the number of mothers who have been taught about weaning foods or about ORT. These services or products are known as output indicators and are usually the easiest to measure. This kind of indicator tells you what you have done, but not necessarily whether what you have done has had the desired effect. An example would be that you built ten smokeless fireplaces in two months.
2. Behaviors, which tell you whether a mother is actually using the smokeless fireplace, that she is in fact feeding her child the weaning foods, or that she is preparing ORT properly. These forms of measurement are known as outcome indicators. They are much more difficult to measure, but they tell you whether what you did had the effect you intended. An example would be that mothers in five of the homes where you built smokeless fireplaces are in fact using them.
3. Changes in the health status of the targeted population, which tell you whether there has been a decrease in the morbidity or mortality rate, that is, whether there are fewer cases of ARI, malnutrition, and children suffering from diarrhea and dehydration because of your intervention. These forms of measurement are known as impact indicators. They tell you what the impact of the effect you intended was on child health conditions, if any. An example would be that due to the fact that a certain number of mothers are using smokeless fireplaces in their homes, the incidence of ARI has decreased by 10 percent. To measure the overall impact of your intervention is a long term and more complicated process that may only be measured over several years and is usually done through formal surveys on the national level.

TRAINEE HANDOUT
PAGE 2 OF 4

MONITORING AN INTERVENTION

As Volunteers, you will be primarily concerned with measuring services, products, and changes in behavior of mothers or other members of the community as a result of your intervention. You may be able to measure the impact of an intervention through monitoring clinic records over a long period of time, but don't get discouraged if you don't see changes right away or even by the end of your service.

PART ONE

As you will be concerned primarily with output and outcome indicators, it's important you understand the differences between these two. As noted above, an **output** indicator is a description of what tasks have been carried out as part of the intervention, regardless of consequences. An **outcome** indicator, as the name implies, describes what the result or outcome was of the tasks you carried out. Both indicators are important, but clearly outputs that don't result in outcomes suggest that your intervention may need some modification.

Below you will find a list of six pairs of items, with each pair containing an output and an outcome. Write **"OP"** in front of the outputs and **"OC"** in front of the outcomes.

1. _____ Number of health workers who received training in topic A in the last quarter.
1. _____ Number of health workers who showed improvement in their execution of topic A skills in the last quarter.

2. _____ Number of pregnant women identified as high risk in prenatal visits.
2. _____ Number of pregnant women receiving prenatal visits.

3. _____ Number or percentage of mothers starting to give appropriate supplemental foods to infants four to six months old.
3. _____ Number or percentage of mothers who received information on weaning foods and practices.

4. _____ Number or percentage of health workers who counsel mothers on preparation and administration of ORT.
4. _____ Number or percentage of mothers who can describe the steps in preparing and administering ORT.

5. _____ Number of condoms distributed to target population.
5. _____ Percentage of population reporting sex with use of a condom.

6. _____ Number of homes given window screening.
6. _____ Number of homes who have installed screens on their windows.

TRAINEE HANDOUT
PAGE 3 OF 4

MONITORING AN INTERVENTION

PART TWO

In this part of the exercise, you will be going through the process of identifying a goal for your sample intervention and setting up a monitoring system. You have three tasks, as outlined on the accompanying worksheet:

1. Define a goal, describing who, how many, by when.
2. Based on the goal, establish one or two indicators.
3. Decide how often you will monitor the progress of the intervention.

The main point is to keep the task of monitoring as simple and uncomplicated as possible. To that end, be realistic in setting your goal, don't have too many indicators, and make your indicators easy and feasible. Plan to monitor frequently enough to get a good idea of what is happening early on in your intervention but not so often that it becomes a burden and you give up monitoring all together.

TRAINEE HANDOUT
PAGE 4 OF 4

MONITORING AN INTERVENTION

WORKSHEET

Acute Respiratory Infections

Baseline data: % of children suffering from ARI
% of homes that have smokeless fireplaces

Goal(s) of intervention: (who, how many, by when)

Indicators:

How often will you monitor (collect information to measure against indicator):

Malnourishment

Baseline data: % children suffering from malnutrition

Goal(s) of intervention: (who, how many, by when)

Indicators:

How often will you monitor (collect information to measure against indicator):

Dehydration

Baseline data: % of children suffering from dehydration

Goal(s) of intervention: (who, how many, by when)

Indicators:

How often will you monitor (collect information to measure against indicator):

SESSION PLAN

PART FIVE–SESSION 11.3:

MAKING ADJUSTMENTS OR CHANGES IN AN ONGOING INTERVENTION

OVERVIEW

The purpose of monitoring is to see what is working and not working early on in the intervention. In this session the Trainees will discuss possible things that could go wrong and what they can do about it.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Identify when to adjust or make changes to an intervention.
2. Practice making adjustments to an intervention.

TIME

20–30 minutes

MATERIALS

Handout: *Making Adjustments or Changes in an Ongoing Intervention*

DELIVERY

STEP 1. Explain the purpose of this session.

STEP 2. Distribute the handout *Making Adjustments or Changes in an Ongoing Intervention* and ask the Trainees to divide up into their original groups. Go over the example and ask them to complete the exercise.

STEP 3. Reconvene the groups and ask each one to report out. Discuss their points on what was not working and the adjustments they made. Then add any country-specific points or issues that they should be aware of.

TRAINEE HANDOUT
PAGE 1 OF 2

MAKING ADJUSTMENTS OR CHANGES IN AN ONGOING INTERVENTION

Things don't always work as you planned. If you are monitoring correctly, you will see what is working and not working early on in your project. This is the purpose of monitoring.

EXAMPLE:

The District Health Officer (DHO) in Chandrapur checked his immunization record at the end of each week. During week one he saw that they had immunized 80 children. This was under target, but not too bad. But by the end of week two only 40 children were immunized and he decided to analyze the problem. He sent his team out to do home visits and to talk to the mothers about the program. He wanted to know 1) if the mothers had heard about the program, and 2) if they had heard about it, why didn't they bring their children into the clinic.

The team came back and reported that all of the mothers had heard about the program. There were two reasons why they could not and would not come in. 1) It was the planting season and they were out in the fields during the time when the immunizations were being given. 2) Some mothers who had had their children immunized came back and reported to the others that they had to wait a long time in the clinic and that they were treated brusquely by the some clinic staff.

The DHO adjusted the times of the clinic to meet the needs of the mothers and hired more staff on a short-term basis to help with the work. He called a meeting of his staff and spoke to them about treating the patients with more respect.

Then he continued monitoring.

In this part of the exercise, think up some possible (hypothetical) things that might not be working in your intervention based on your monitoring plan. Then figure out what to do about it or what adjustments you would make to ensure success. You can use the information you have gathered about the community in your child health notebooks to help you.

TRAINEE HANDOUT
PAGE 2 OF 2

MAKING ADJUSTMENTS OR CHANGES IN AN ONGOING INTERVENTION

Acute Respiratory Infections

What's not working and why:

Adjustments you would make:

Malnourishment

What's not working and why:

Adjustments you would make:

Dehydration

What's not working and why:

Adjustments you would make:

SESSION PLAN

PART FIVE–SESSION 11.4:

EVALUATING AN INTERVENTION

OVERVIEW

Evaluation is looking at the actual work after it is completed and comparing it to the work that was planned at the beginning. It is an assessment of the intervention as a whole. In this session the Trainees will learn about the criteria for evaluating an intervention and how to apply it.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Present criteria for evaluating an intervention.
2. Practice evaluating an intervention.
3. Explain the differences between monitoring and evaluating a small intervention and a larger, long-term intervention.

TIME

20–30 minutes

MATERIALS

Handout: *Evaluating an Intervention.*

PREPARATION

Ask the Trainees to bring their design process grids with them to this session. If the Trainees met with the community to design an intervention, ask them to bring the design process grid for that intervention as well.

DELIVERY

STEP 1. Explain the purpose of this session and distribute the handout *Evaluating an Intervention*. With the entire group, explain the meaning of evaluation and go over the criteria. In order to apply these criteria and come up with the answers, the person doing the evaluation needs to go back to the baseline data and the monitoring goals. Then they should compare this information with the information that was collected during the monitoring process.

STEP 2. Ask the Trainees to look at the intervention plans that they came up with in Step 6 of the intervention design process. Ask them to complete the grid, either in small groups or all together.

If the Trainees designed an intervention with the community in the session **Designing an Intervention with the Community**, p. 260, ask them to look at those plans and go through the steps in the monitoring and evaluation process for that intervention and complete the grid. They may do this either in small groups or all together.

STEP 3. Bring the groups back together (if broken into groups) and discuss their monitoring and evaluation plans. Answer their questions and add anything you think is missing.

STEP 4. Discuss the differences between monitoring and evaluating a small intervention (such as the one they will do with the community during PST) and a larger, long-term intervention. For a smaller, short-term intervention, they may only be able to use and measure output indicators. It will be more difficult to measure outcome indicators because this requires time.

STEP 5. Give examples of projects in-country that have been successful or have failed. (Consult with the APCD if necessary.) Discuss why these projects had the outcomes they had. Ask the group if anyone has worked or observed a project that has succeeded or failed and have them explain why.

STEP 6. If the Trainees designed an intervention with the community, they should meet with the community members again and take them through the process of designing a monitoring and evaluation plan. Prepare the Trainees for this meeting and set up a time and date to do so (if not already set). For this meeting follow the same format for facilitating a community meeting as before.

STEP 7. If the Trainees carried out an intervention with the community, then you should meet with them after the intervention is completed and evaluate the intervention using the criteria outlined in the Trainee handout, and process their experience working with the community to develop the monitoring and evaluation plan.

TRAINEE HANDOUT
PAGE 1 OF 2

EVALUATING AN INTERVENTION

Evaluation is looking at the actual work completed and comparing it to the work that was planned in the beginning. It is an assessment of the intervention. In other words, was it a success and did it meet the health needs of the community?

When evaluating or assessing an intervention, you should use the following criteria:

1. **Was the intervention adequate?**

   Given the size of the problem, did the intervention make enough of a difference to be worth the effort?

2. **Was it appropriate?**

   Was it appropriate for the situation or given problem?

3. **Was it effective?**

   Did it achieve the stated goal?

4. **Was it cost-effective?**

   How costly was the intervention compared to the benefits obtained?

5. **Was it timely?**

   Was this the right time to address the problem?

6. **Were the outcomes sustainable?**

   Are the people in the target group continuing to change?

EXAMPLE:

At the end of two months, the DHO in Chandrapur looked through his records and found that his team had given 700 immunizations. They had attained 90% of their goal. He then applied the evaluation criteria (above). He decided it was worth doing; that it was appropriate given the infant mortality rate, due to measles, in the community and the effectiveness of the vaccine; that it was effective given the 90% success rate; it was cost-effective since the vaccines were donated by UNICEF and he only had to pay for transportation; and it definitely was efficient and timely.

TRAINEE HANDOUT
PAGE 2 OF 2

EVALUATING AN INTERVENTION

Now look at the Design Process grid that you worked on in the session **Designing an Intervention 2: The Process**, p. 252, and complete Step 6 of the design process using the hypothetical data as directed by your technical trainer.

SESSION PLAN

PART FIVE–SESSION 12.1:

HEALTH PRESENTATIONS AND PRINCIPLES OF ADULT LEARNING: A QUIZ FOR PRESENTERS

OVERVIEW

This session introduces Trainees to a number of the key themes in health/adult education, many of which will be covered in more detail in other exercises in this section.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Explain key concepts in making health presentations.
2. Assess their own knowledge of the principles of giving presentations

TIME

45–60 minutes

MATERIALS

Handouts:

- *A Quiz for Presenters*
- *Quiz Answers and Discussion*

PREPARATION

You may get some argument about some of the answers, so you should read the answer handout carefully and be ready to make your case. In the end, do not argue with the Trainees; just move on. Anything they are not convinced of at this point, they will be convinced of by the end of this section.

The quiz, worksheet, and handout in this session and the next one cover the same material. Read both sessions and determine how you wish to present this material; using all three handouts is redundant.

DELIVERY

STEP 1. Introduce the activity by saying that the object is to introduce some of the important concepts in training, most of which will be covered in more detail in subsequent exercises.

STEP 2. Distribute the quiz and ask Trainees to answer the questions on their own.

STEP 3. Go over the answers. At the end, distribute the second handout *Answers* for them to have as a reference.

TRAINEE HANDOUT
PAGE 1 OF 3

A QUIZ FOR PRESENTERS

Answer the following true or false.

1. _____ If your topic is important to people, they will pay attention to your presentation.

2. _____ A presenter should speak in a conversational voice so that he or she sounds natural.

3. _____ Most adults can concentrate for roughly half an hour; then they need a break like children.

5. _____ Adults prefer to listen rather than become involved in a presentation.

6. _____ Experienced presenters focus closely on their style and delivery.

7. _____ In designing a presentation, begin by deciding what information you want to convey to the audience.

8. _____ Your listeners will remember approximately three key points of what you say.

9. _____ Most training includes follow-up, which supports behavioral change.

10. _____ Most educated professionals are exposed to good trainers in the course of their education.

11. _____ Most members of an audience are slightly hostile to a presenter and later become more sympathetic.

12. _____ In general, people in your audience are positively disposed toward changing their behavior.

TRAINEE HANDOUT
PAGE 2 OF 3

A QUIZ FOR PRESENTERS: ANSWERS AND DISCUSSION

1. ______ If your topic is important to people, they will pay attention to your presentation.

False. If only this were true, then all presenters would have to do would be to choose the right topic and every presentation would be effective. In fact, it has been shown that something like the reverse of this is true, that if the presentation is good enough, people will pay attention even if they *are not* especially interested in the topic. In any case, getting the topic right is only a small part of a successful presentation. What are the other parts, you ask? Keep reading.

2. ______ A presenter should speak in a conversational voice so that he or she sounds natural.

False. Giving a talk is not having a conversation. If the speaker who is presenting sounds natural, that is, uses a normal tone of voice and style of talking, she/he will not hold people's attention, to begin with; will not sound very interesting; and will not make much of an impression. If you are not going to be interesting or make an impression, why are you giving a talk? See the session **The Presentational Voice**, p. 301.

3. ______ Most adults can concentrate on a lecture for roughly half an hour; then they need a change of activity.

False. The attention span is closer to 5–10 minutes. This is reason you cannot stand there and talk for half an hour when you are presenting. You have to change the activity or technique every 10 minutes or so, to hold the attention of your audience. Vary the presentation using visual aids.

4. ______ Presenters should avoid recycling or repeating ideas so participants do not feel they are being treated like children.

False. Key ideas need to be repeated so people will remember them. People's attention will wander in and out of your talk. If you only make your main points once, and that's when my mind was off somewhere else, I never hear them. But if you repeat them, then chances are I will hear them at least once.

5. ______ Adults prefer to listen rather than become involved in a presentation.

False. Adults usually have things to say, things to contribute to a presentation. Try to involve them.

6. ______ Experienced presenters focus closely on their style and delivery.

False. Novice presenters typically focus on style and delivery, but experienced presenters (who already have strong delivery skills) focus on their audience and their content. That is, they note how the audience is reacting and make adjustments to their presentation, if necessary. Beforehand, they decide what content, and how much content, is appropriate to present. Then they design a good talk.

TRAINEE HANDOUT
PAGE 3 OF 3

A QUIZ FOR PRESENTERS: ANSWERS AND DISCUSSION

7. _____ In designing a presentation, begin by deciding what information you want to convey to the audience.

False. Decide first what you want to have happen as a result of this talk. In health presentations, the goal of your talk is usually some kind of behavior change. Decide first on the behavior change you desire, then decide what you have to say (the information or content you have to convey) to make that change happen. Don't say more than that.

8. _____ Your listeners will be able to remember approximately three key points of any lecture.

True.

9. _____ Most training includes follow-up, which supports behavioral change.

False. Most presenters do not have (or schedule) an opportunity to do a follow-up presentation, but follow-up is a good idea in designing any kind of talk or health intervention. If there is no other opportunity to discuss your topic, then your talk is the one chance you get to make an impression and change behavior. So make the most of it.

10. _____ Most educated professionals are exposed to good trainers in the course of their education.

False. Academics get their job because they know their content, not because they are good speakers. The same is true for many other presenters. Most of us see very few good presenters in the course of our education. Thus, we do not have a good sense of what it takes.

11. _____ Most members of an audience are slightly hostile to a presenter and later become more sympathetic.

False. Usually people start out giving the presenter the benefit of the doubt, wishing him/her well. If the presenter is not good, the audience may lose interest.

12. _____ In general, people in your audience are positively disposed toward changing their behavior.

False. In general people would rather stay the way they are, even when they know it's not good for them. Changing behavior is difficult. You have an important job ahead of you.

SESSION PLAN

PART FIVE–SESSION 12.2:

SOME THINGS TO KNOW WHEN TRAINING ADULTS

OVERVIEW

In order to design and deliver health talks to adults, Trainees need to know certain characteristics of adults related to how they learn in training sessions. This session presents the important characteristics and asks Trainees to think of the implications for giving presentations.

OBJECTIVE

By the end of the session the Trainees will be able to list important points to remember in training adults.

TIME

20–30 minutes

MATERIALS

Handouts:

- *Some Things to Know When Training Adults*
- *Some Things to Know When Training Adults: Implications*

Flip chart paper and markers

DELIVERY

STEP 1. Introduce the session by asking how are adult learners different than children? Discuss but do not list.

STEP 2. Explain that they will have a chance to think about what the characteristics mean to them as presenters. Distribute the handout, *Some Things to Know When Training Adults.* Divide the Trainees into groups and have them complete the handout. Be sure to emphasize that what they are to write under each item are implications of this item for designing/delivering presentations to adults.

STEP 3. Reconvene and discuss the Trainee answers for each item.

STEP 4. Distribute the *Implications* handout and suggest they add any items from the discussion.

STEP 5. Close by telling Trainees to keep these things in mind when they design their own presentation in the session **Designing and Delivering a Health Talk**, p. 304.

BEST COPY AVAILABLE

TRAINEE HANDOUT
PAGE 1 OF 5

SOME THINGS TO KNOW WHEN TRAINING ADULTS

Whenever you give a talk or presentation, the better you understand your audience the more effective you will be. This exercise presents some characteristics of adults which have special significance for giving health talks. Read these eight factors, as described below, and note in the space any implications you can think of for trying to train such people.

1. **The HOMEOSTASIS Factor:** Homeostasis is a term used in biology to denote the natural tendency of an organism to stay the way it is rather than to evolve into something else. In training, it means you should assume that the people in your audience do not want to change or have to do things differently; they would much prefer to do things the way they already do.

2. **The MEMORY Factor:** Adults remember very little of what they hear, and much of what they do remember is stored in what is called the short-term memory where it is retained for only a few minutes.

3. **The EXPERT or AUTHORITY Factor:** Adults want a presenter to be—or at least act like—an expert or an authority. They want the presenter to obviously know the material and to be confident. Adults are more likely to listen to something if it comes from an expert.

TRAINEE HANDOUT
PAGE 2 OF 5

SOME THINGS TO KNOW WHEN TRAINING ADULTS

4. **The INVOLVEMENT Factor:** Adults have experience, opinions and therefore things to share. They like to be involved in a presentation, to participate rather than merely listen.

5. **The FULL PLATE Factor:** Adults already have many things to do and busy schedules. They may not want to complicate further an already very hectic life.

6. **The ATTENTION Factor:** Adults can only listen for a few minutes. Then they get distracted and start thinking about other things, or they get bored and want to leave.

7. **The MORALE Factor:** Research shows that people are much more likely to remember and respond to a speaker whom they really enjoyed, who made their talk interesting, fun, a pleasant experience—regardless of the topic. In other words, if the audience enjoys you, they will like and probably remember your message.

Trainee Handout
Page 3 of 5

Some Things to Know When Training Adults: Implications

1. **The HOMEOSTASIS Factor:** Homeostasis is a term used in biology to denote the natural tendency of an organism to stay the way it is rather than to evolve into something else. In training, it means you should assume that the people in your audience don't want to change or have to do things differently; they would much prefer to do things the way they already do.

   - Persuading people to change their behavior will not be easy.
   - Be realistic about what you can ask people to do.
   - Make a very strong case for change.
   - Try to inspire.
   - Other: ____

     ____

     ____

     ____

2. **The MEMORY Factor:** Adults remember very little of what they hear, and much of what they do remember is stored in what is called the short-term memory where it is retained for only a few minutes.

   - Limit your content; do not ask people to remember too much.
   - Reinforce your main points in various ways.
   - Have a variety of activities to get your message across.
   - Use visual aids to reinforce your message.
   - Involve your audience. People remember better when they are participating, not just listening.
   - Be as dynamic as you can.
   - Other: ____

     ____

     ____

     ____

TRAINEE HANDOUT
PAGE 4 OF 5

SOME THINGS TO KNOW WHEN TRAINING ADULTS: IMPLICATIONS

3. **The EXPERT or AUTHORITY Factor:** Adults want a presenter to be–or at least act like–an expert or an authority. They want the presenter to obviously know the material and to exude confidence. Adults are more likely to listen to something if it comes from an expert.
    - Talk in a strong, presentational voice.
    - Be organized and well prepared. Try not to falter or lose your train of thought.
    - Practice your talk ahead of time so it looks polished and professional.
    - Other: ______________________________
      ____
      ____

4. **The INVOLVEMENT Factor:** Adults have opinions and things to say. They like to be involved in a presentation and to participate rather than merely listen.
    - Wherever possible, solicit information rather than present it.
    - Design activities that require audience participation.
    - Ask questions.
    - Other: ______________________________
      ____
      ____

5. **The FULL PLATE Factor:** Adults already have more on their plate than they can handle. They don't want to complicate an already very hectic life further.
    - Be specific about what you are asking people to do.
    - Simplify your message as much as possible; ask only what is essential.
    - Make a very strong case; be very clear about benefits/rewards or hazards/dangers (of not changing behavior).
    - Keep your talk simple, uncluttered with extraneous details.
    - Other: ______________________________
      ____
      ____

TRAINEE HANDOUT
PAGE 5 OF 5

SOME THINGS TO KNOW WHEN TRAINING ADULTS: IMPLICATIONS

6. **The ATTENTION Factor:** Adults can only listen for a few minutes. After that they get distracted and start thinking about other things, or they get bored and want to leave.

   - Use a strong, presentational voice.
   - Involve the audience.
   - Do something different every five minutes or so; use a variety of techniques/activities to make your points.
   - Use visual aids.
   - Repeat key points.
   - Other: ______________________________

   ____

   ____

   ____

7. **The MORALE Factor:** Research shows that people are much more likely to remember and respond to a speaker whom they really enjoyed, who made their talk interesting, fun, and a pleasant experience—regardless of the topic. In other words, if the audience enjoys you, they will like and probably remember your message.

   - Use a strong, presentational voice.
   - Use visual aids.
   - Get audience participation.
   - Keep it lively with a variety of techniques.
   - Other: ______________________________

   ____

   ____

   ____

SESSION PLAN

PART FIVE–SESSION 12.3:
THE GREAT MYTH OF TRAINING

OVERVIEW

This exercise examines in more detail the basics of good presentations, which have been introduced in the sessions **Quiz for Presenters**, p. 285, and **Training Adults**, p. 290. In this session the Trainees explore the reasons why (a) information transfer does not always lead to retention and (b) why retention does not lead to behavior changes. This is important preparation for the culminating activity in this section of the manual: **Designing and Delivering a Health Talk**.

OBJECTIVES

By the end of the session the Trainees will be able to explain why:

1. Presentations often fail to achieve their purpose.
2. People do not remember what they hear in a presentation.
3. Even though people understand what they heard in a presentation they often do not change their behavior.

TIME

30 minutes

MATERIALS

Flip chart paper and markers

Handouts:

- *The Great Myth of Training*
- *The Great Myth of Training: Possible Answers*

DELIVERY

STEP 1. Introduce the activity, as above.

STEP 2. Distribute the first handout. Divide Trainees into groups and have them complete the handout. Tell them to recall what they learned about presentations in the two previous exercises.

STEP 3. Distribute the *Possible Answers* handout to the groups. Have them compare their answers to the ones presented.

STEP 4. Ask groups to report out only addition they have to the second handout. Also ask them if they have questions.

STEP 5. Close the session by reminding Trainees that these are important considerations to keep in mind as they design a health talk, the last session in this series.

TRAINEE HANDOUT
PAGE 1 OF 2

THE GREAT MYTH OF TRAINING

This exercise asks you to analyze the great myth of training. Simply put, it goes like this: You tell people something (information transfer) and they remember it (retention). And because they remember it, they put it into action (behavior change). Actually, there are two myths here:

1. That people remember things someone told them.
2. That people act on things they have learned about.

If this were so easy, people would no longer smoke or neglect to exercise, among other things people know better than to do. But it isn't so easy. There are many reasons information transfer does not lead to retention, and retention does not lead to behavior change, many of which are beyond your control as a presenter.

In your group, try to think of things that you as a designer/presenter of health talks do or fail to do that causes people to 1) not remember what you tell them, and 2) fail to put into action what they learned from your talk. Write these items below, trying to be specific.

Lack of Information Transfer	**Lack of Behavior Change**

TRAINEE HANDOUT
PAGE 2 OF 2

THE GREAT MYTH OF TRAINING: POSSIBLE ANSWERS

Below are some of the reasons why information transfer does not always lead to retention and why retention does not always result in behavior change. The reasons listed below are confined to matters within the control of a presenter. Think of some additional reasons to add to this list.

Why information transfer does not always lead to retention:

1. The speaker does not use a presentational voice.
2. The speaker has not limited their content and tries to say too much.
3. The speaker does not reinforce or recycle key points.
4. The speaker does not involve the audience.
5. The speaker does not have enough variety in the presentation and people lose interest.
6. The pace of the presentation is too slow or too fast.
7. The speaker does not use visual aids.
8.
9.
10.

Why retention does not lead to behavior changes:

1. The speaker is too ambitious; the behavior change has too many steps and is too complicated.
2. The speaker presents too much information, so the message is not clear.
3. The speaker does not return to all key points so the audience only retains some of what is said.
4. The speaker is not precise enough about what is to be done, so the audience gets the general message (something to do with my hands and food) but not the specifics (I should wash my hands before handling food).
5. The speaker is not very enjoyable, inspiring, or convincing. The audience may remember the message but not be very motivated to do what they are told.
6. The speaker does not present steps concretely, logically.
7. The behavior requested is not clear. There was not a demonstration of what to do.
8.
9.
10.

SESSION PLAN

PART FIVE–SESSION 12.4:
THE PRESENTATIONAL VOICE

OVERVIEW

Very few people's normal speaking voice is adequate for giving a presentation to a group. Hence, Trainees need to understand what a presentational voice is and to practice developing it.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe the presentational voice.
2. Distinguish the presentational voice from the conversational voice.
3. Demonstrate the presentational voice.

TIME

1 hour

MATERIALS

Handout: *The Presentational Voice*

PREPARATION

If possible, every Trainee should give a short, 1-minute presentation during this session. There are many ways to do this. One is to have each Trainee present a particular behavior they feel strongly about and why (eg., shaking hands with people they meet.) Another is to explain how to do something very simple: put on a sweater, hang up a piece of clothing, or make a sandwich.

DELIVERY

STEP 1. Distribute the handout and ask Trainees to complete it on their own.

STEP 2. Discuss the questions.

ANSWERS:

1. Conversational voice:
   - soft, not very loud
   - sentences may be incomplete with little variety in tempo
   - there may be little use of hands or other body movement
   - Tone invites others to speak
2. Because this is all they know or because they have had very little practice, or no instruction, in giving presentations.
3. Presentational voice:
   - louder, projects to back of room
   - variety in tempo: speeds up in some places and slows down in others
   - contains pauses
   - changes in emphasis
   - authoritative, confident, in charge
   - hands and body movements accompany appropriate verbal clues
4. To get the audience's attention
   - To keep the audience's attention
   - To create and sustain interest
   - To project authority and competence
   - To keep control of the session
   - To create a positive attitude in the listener

STEP 3. Give Trainees their assignment for a talk with 10 minutes to prepare. Remind them that the purpose of the presentation is to use a presentational voice. Keep this moving fast or it will start to drag. After a group of five or six, stop and ask about their use of presentation voice: volume, clarity, animated. If you have a big group, Trainees can be divided into half or thirds, and present in the smaller groups. They can process their own work.

STEP 4. Ask how the experience was. For those who found it difficult, have them strategize on how to do better next time.

TRAINEE HANDOUT

THE PRESENTATIONAL VOICE

Giving a talk to a group is not the same as having a conversation with someone. For the latter you use a conversational voice; for health talks, you need a presentational voice. What are the differences in these two voices? Think about the settings in which they are used and the purposes of the interaction. Then take some notes below.

1. What are the characteristics of a conversational voice?

2. Why do many people speak to groups in a conversational voice?

3. What are the characteristics of a presentational voice?

4. Why is a presentational voice more effective for speaking to groups?

SESSION PLAN

PART FIVE–SESSION 12.5:
DESIGNING AND DELIVERING A HEALTH TALK

OVERVIEW

The ability to design and deliver a health talk is an important skill for Volunteers to acquire. This session provides a model and a chance to practice this skill.

OBJECTIVES

By the end of the session the Trainees will be able to:

1. Describe a model for designing a health talk
2. Deliver a health talk.

TIME

20 minutes for each Trainee (10 minutes to give their talk and 10 minutes more or less to debrief). This does not count the time needed to plan and prepare their talks which should be done prior to this session.

MATERIALS

Handouts:

- *Designing and Delivering a Health Talk*
- *Presentation Observation Sheet*

STAFF

You may wish to invite the language trainers and/or technically qualified host country nationals as observers in this session to give their comments and observations on the technical content or appropriateness of the presentation from a host country national's perspective. Check with the Trainees first to make sure that the presence of an HCN does not make them uncomfortable during their presentations.

PREPARATION

Announce early in the training that each Trainee will be expected to give a 10-minute health presentation at some point. Who they give it too, and in what language, should be part of the introduction. Distribute the handout and have them read through the example. Explain that they have received the information now so they can think about possible topics during the training.

After you have started the Health Presentations module, tell Trainees to start planning their talks. Have trainees sign for the day they would like to present. Also announce who will be observing and critiquing, and make sure everyone gets the *Presentation Observation Sheet* handout.

DELIVERY

STEP 1. Trainees will deliver their talks to the agreed-upon audience, with observers in attendance. If you can arrange videotaping, this is a good idea. Give the tape to the Trainees afterwards for their own use.

STEP 2. After the talk, Trainee and observers should meet for debriefing, using the observation sheet as a guide.

STEP 3. Following all the presentations and debriefings, ask the Trainees to discuss what characteristics of the talks made them interesting, easy to understand, convincing. Ask each person how he or she might improve their presentation.

RESOURCES

Nonformal Education Manual, Developing visual aids from local materials, Chapter 8

TRAINEE HANDOUT
PAGE 1 OF 4

DESIGNING AND DELIVERING A HEALTH TALK

In this exercise, you will put together all you have learned about training and adult learners with what you know about health problems in your community and design a health talk on a topic of your choice. You may be working on this exercise over a period of days or weeks, but these are the steps you need to follow:

1. Select a topic which would normally have something to do with a major child health problem in your community.

   Example: Diarrhea

2. Select an appropriate audience. This should be people who are somehow affected, whether directly or indirectly, by the problem. They might be people who experience the problem or who can be instrumental in the solution, or both.

   Example: Mothers with young children who visit the local clinic.

3. Decide on what behavior change you want to have take place as a result of your talk.

   Example: I want these mothers to start washing their hands before they handle food.

4. Decide on your main points, what you have to explain in order for your audience to be able to do the change you have identified in above number 3.

   Example: A lot of your children have diarrhea.

   Diarrhea can be dangerous for young children.

   One way they get diarrhea is through contaminated food.

   Food sometimes gets contaminated by you not washing your hands.

   You need to wash your hands before you handle food.

TRAINEE HANDOUT
PAGE 2 OF 4

DESIGNING AND DELIVERING A HEALTH TALK

5. Decide what you're going to say about each point and how you're going to support or develop it.

Example: A lot of your children have diarrhea.

- Tell an anecdote.
- Give examples.
- Ask audience a question.
- Give statistics.

Diarrhea can be dangerous for your children.

- Give examples of how this is so.
- Tell a story about so-and-so.
- Ask an audience member to tell a story.

One way they get diarrhea is through contaminated food.
Food gets contaminated by you not washing your hands.

- Use visual aids.
- Do a demonstration.

You need to wash your hands before you handle food.

- Demonstrate how.
- Explain for how long.
- Have everyone try.

6. Create and/or arrange for any visual aids, handouts, participation, etc. you will need.

7. Review your design to check for the following:
   - Is the content limited?
   - Is there participation?
   - Is there variety?
   - Are there visual aids?
   - Do main points get reinforced?

TRAINEE HANDOUT
PAGE 3 OF 4

PRESENTATION OBSERVATION SHEET

Use this sheet for observing the health talk(s) you have been asked to critique. Write comments on this page. You will be giving this to the person you observed after the talk.

1. State two or three good things about the presentation.

2. **Goal:** What do you think about the goal (behavior change) the presenter selected?

3. **Content:** Was the content clear? Sufficiently limited?

4. **Participation:** Did the presenter get audience participation? Did it work?

5. **Voice:** Did the presenter use a presentational voice?

337

TRAINEE HANDOUT
PAGE 4 OF 4

PRESENTATION OBSERVATION SHEET

6. **Variety:** Was there variety in the presentation?

7. **Visual aids:** Did the presenter use visual aids? Were they good?

8. **Reinforcement:** Did the presenter reinforce the main points?

9. **Authority:** Did the presenter seem in charge?

10. **Retention:** Do you think the audience will remember the main points? Why?

11. **Behavior change:** Will the audience be able to do the thing the presenter wants them to do? How do you know?